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Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology

Issue 10 - Evidence

OTTAWA, Wednesday, March 29, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill S-5, to amend the Parliament of Canada Act (Parliamentary Poet Laureate), met this day at 3:41 p.m. to give consideration to the said bill.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: We are here today to consider Bill S-5, which is Senator Grafstein's bill to establish a poet laureate for Canada.

Hon. Jeremiah S. Grafstein: Honourable senators, it is a privilege to appear before you. This is the second time in my life that I have appeared as a witness before a Senate committee. The first time was over two decades ago, when I appeared before Senator Davey's committee on the media. Today marks the second time, which is the first time I am appearing in my capacity as a senator as well as the proposer of this bill. I thank you for the privilege of attending here before you.

The motivation for this bill - the digital era of media convergence is upon us, pushing us, crowding us and, some say, crushing us. We witness electronic perceptions easily morphed into virtually reality. By zapping or clicking endless images, messages are seamlessly reorganized and transformed. Senses are swamped by the warp and the woof of this unreal world. Our shared heritage, the canons of the word, are almost drowned out by this digital age. We fear our children are becoming grammatically illiterate, and worse, culturally ignorant. Just as Parliament is predisposed as a check on state powers, so poetry can provide a reality check on the confusing image chaos and information fog rampant in our civic society.

In this collectivizing age, we need many more platforms for stronger individual voices. As a modest counterweight to this digital tidal wave, I would argue that we need more poetry -- we need poetry more than ever before. From this worrying, spinning society, a virtual cycle has suddenly emerged, a surprising revival, a renewed interest in poetry and poetry readings. Some spontaneous readings are called "poetry slams," and I ask myself why.

Poetry works to boil ideas to their essence. It steps back and reorients virtual reality. Poetry exposes the individual aesthetic. It helps us look inwards to ourselves and beyond our situation more clearly. At times, poetry and virtual reality are almost like competing entities of truth.

Some observers complain that virtual reality is springing out of control, magnifying otherwise inert forces and nascent feelings of dislocation, isolation and alienation in our society. Just think, honourable senators, of the games children play today.

The speed of digital change seems, in itself, disorienting. In turn, malaise, ruthlessness and apathy eat away and displace a country's nurturing common dreams and shared values as societal anchors. Violence erupts when common values we share fragment, erode or implode too quickly. Poetry can ease and soften the impact of these forces of distortion, so overloaded as they are with floods of information that make our modern life so confusing and disorienting. Sometimes, honourable senators, one speech can become a prose poem that binds a country and its people together, armed only with the simple phrase or a thoughtful metaphor.

As Robert Pinsky, the American poet laureate argues, that "in its proper place" poetry may bring "harmony from disharmony, understanding from confusion." Poetry and the written word can help us refocus. In this 24 x 7 world, time is the essence. Poetry can freeze experience and then defrost, with a word, a phrase, a line, a paragraph, a verse, a poem, a metaphor.

Walt Whitman argued that the United States was so immense, so fragmented, so disparate and so divided that, if it could only be held together by one thing, it would be by poetry. Untutored forces can work in an unintended way, without our assent, to press us together in crushing conformity. Our society needs other visions, alternate vices, fresh breathing room, more thinking time, different rhythms.

Poetry and poets can give us space, give us pause to analyze our society and our own work in slower motion. Now some scoff at poetry, demeaning its rich record of history. Some argue that poetry has simply no place associated with political power. Associating with Parliament can only taint poetry, they say. Poets would be held in bondage by the poet's association with Parliament. There is some force to this argument.

For over a century, those three miserable "isms," -- communism, fascism and nazism -- all organized to harness the poet's art to the uses of state power; yet our Parliament was created precisely as a popular check on state power. Hence, the model that informs this modest millennium recommendation is that the cabinet, the executive of state power, would have no hand in the selection of the poet laureate. The process proposed here is quite simple. The leaders of our major cultural institutions, the Library of Parliament, the National Archives, the National Library, the Canada Council and the Official Languages Commissioner would biannually propose nominees. Poets, their societies, writers and the public alike would be encouraged to lobby for these selections. Three people would be nominated, and from these, the Speaker of the House of Commons and the Speaker of the Senate would take a decision. The poet laureate would serve for only two years, with minimalist responsibilities. He or she would act freely as a catalyst to bring poetry to the heart of the public dialogue, to heighten public awareness.

Robert Pinsky, the poet laureate consultant of the United States, pointed out that the great English poet, William Blake, was quoted more often in the British House of Commons than any other source. The power of poetry is potent. Everything we do here is based on words. Words are the only business of parliamentarians. Some argue Parliament that works in a cocoon, immune to the realities of life since Parliament can deal mostly in laws that please the largest numbers. The poet laureate can place a mirror before Canadians that refracts different images of life. He can parse our common lexicon in different ways. We need diversity of thought to create a unity of dreams and a unity of visions. Poetry might even add some greater sense and sensibility to the word factory of Canada -- to our Parliament. Poetry might bring fresh realities, new light, to the very heart of the Canadian soul, wherever it may reside.

Honourable senators, for your careful deliberations, I propose this bill, this most modest millennium idea, for consideration and, I hope, for positive commendation by this committee.

Senator Carstairs: Senator Grafstein, you have fallen, unfortunately, I think, into a trap, a trap that I keep hearing from so many people, that somehow or other our children are illiterate. I take great exception to that. I think children are more literate today, in so many areas, than they have ever been in their history. When I was in school, I was asked to memorize poetry. Nobody asked me to write it. Children in grade 1 are asked to write Haiku, and taught how to do. In grade 5, they are asked to write sonnets. This is a very creative period in our time. I do not think it deserves the kind of negativism in your statement.

What you are your comments?

Senator Grafstein: The words I used were "grammatically illiterate" and "culturally ignorant." I was focused on a different proposition, that there are two streams of history. One is the poetic stream of history and the other is the prose stream of history. The things that I remember best of history are the poems we were taught to memorize.

When it comes to history in this country, the common heritage and values, I doubt if one could make the argument that we are doing a good job in our schools. I say that because, when you ask children who are in public or private school, secular or non-secular school, who is the prime minister, what is the nature of Parliament, what is the nature of senators, they can tell you about Clinton and Gore but they cannot tell you about Chrétien and Manning.

Therefore, I agree with you. I did not mean to suggest that children are illiterate; I said "grammatically illiterate," which I still contend they are, to a greater extent than we were. There is an absence of an understanding of the cultural things that bind us together.

I hope, Senator Carstairs, that that modest argument will not deter you from supporting this bill.

Senator Carstairs: My second question is related to a submission that we will hear a little later, a submission that, in my opinion, is of great significance. That is, the Library of Parliament in a brief submitted to us argues, very effectively, that if we are to move to a poet laureate we should in fact have two, one in both official languages, or at least a poet who could write poetry in both official languages. I am not sure that that is possible. I personally would be happier with two rather than one.

What would be your reaction to such an amendment?

Senator Grafstein: You touch on a very important and central point. I have given this issue more thought than the rest. I concluded, after consulting, that what we were looking for in a parliamentary poet laureate was absolutely the best poet in Canada. We have, in this country, a grand tradition of translation. In a way, we demean both official languages if we were to conclude that we needed to have two where one would do. I do not think that that person necessarily must be bilingual. We are able to have strong, creative and intelligent translation.

Unlike in England, I proposed that we have a short term for a parliamentary poet laureate. A new person would be selected every two years. We do not have two prime ministers. We do not have two Governors General. We have one to represent the common values. Our power to be able to listen to that person in his or her original tongue or through translations would suffice.

One of the greatest poets of the century is Rilke. You should read a book by Rainer Maria Rilke, entitled *Letters to a Young Poet*. It is a book that I would urge every parliamentarian to read. It will improve his or her diction.

There is also a recent book, called *Reading Rilke: Reflections on the Problem of Translation*, written by a great literary critic in the United States called William H. Gass. He deals fundamentally with the issue we are discussing. The argument he makes is that it is important to listen to the voice of a poet in that person's language. I would prefer to have a superb francophone, who is a great poet, or an aboriginal, or somebody who speaks Chinese, writing in their language, and select that person as opposed to dealing with the question of trying to accumulate the creative talents into one person. I do not think the idea of official bilingualism would be hurt by this process. In fact, I think it would be enhanced.

Therefore, I do not agree with those who say we need two poets laureate. We have one Canada, one country. I think the ability to alternate quickly would give every region, every sector, part and language in this country an opportunity to have their voice heard.

Senator LeBreton: At the end of your submission, you said: "The power of poetry is potent." How can poetry be translated? It is written in the language it is written in. How would the power of poetry be potent if we were dealing with a translation, because then does it not lose its potency?

Senator Grafstein: That is part of the argument that Gass makes. Rilke has been translated into many

languages. What Gass does is take five or six English translations of Rilke from the German and parse them, and indicates how they have lost their essence in moving from one language to the other. You can get a feeling of poetry in a different language, but you cannot get the inner essence of that language. I argue for excellence of thought and excellence of expression. I do not think that hinders the alternate's proposition. In the course of a decade, we will have, if it works properly, practically every region, every language and every group represented, because that person will represent the best of Canada. I do not see it as two warring ideas.

Senator Roche: To have a poet laureate is a step forward in our civilization, and I congratulate Senator Grafstein for bringing forward this bill. Senator Grafstein has given us a rationale for this, that the poet laureate, in the poem, goes to the heart of the dialogue, that the very essence of our society, in passing through these various moments, is caught by the sheer eloquence of the word. That was probably true 100 years ago, for indeed the idea of the poet laureate comes out of the age of the word; but we now live in a society of visual images.

I put it to Senator Grafstein: What is your opinion of the picture of the globe that was sent back by the astronauts from space? We see a beautiful blue globe, spinning in space, shimmering. The unity of the whole world is seen in that one photograph of earth. We are the first peoples to be able to see ourselves as a whole. The magnificence of that photograph is but one example of how the heart of the dialogue and the heart of the moment can also be captured visually in a photograph as well as in a poem.

Therefore, if we are to have a poet laureate, what about a photographer laureate? In that way, we would be able to recognize the transition to the visual age in which we live in, which complements the age of the word?

Senator Grafstein: I have no objection to having a photographic laureate. I could give you the biblical version of my position -- we all know it very well: "In the beginning was the Word." In the beginning, they did not say, "In the beginning was the picture of the word." They said: "In the beginning was the Word."

We communicate by words. Yes, we do communicate by pictures; however, our mental processes originate with words. We are being overloaded with images, and they are confusing. If a person sits at home and watches television, that person can zap together some asymmetrical view of life that has nothing to do with life. I call it virtual reality, but it is unreal.

You can examine history through words. Read Samuel Johnson's *Lives of The Poets* and then read Thomas Carlyle's works on history. In my opinion, you will get a better grasp of what went on in society by reading Samuel Johnson's *Lives of The Poets* than by reading the historians, Carlyle being an example. They have a sense of boiling things down to their essence.

So, yes, photography is important and, yes, we live in a digital and photographic world, and nothing will stop that. We need a modest counterweight to give platforms to the written word. We are not on opposite poles here. You have simply said that we need both. The problem for me -- as I am sure it is for many of us -- is that the word is being drowned out by false images. Truth is sometimes drowned out by images that distort reality.

What is wrong with elevating or giving a platform to the spoken and written word? Is it not a modest counterweight to everything that is going on in the world? Is it not in some ways more helpful? It is a philosophical issue as well as a technological issue.

Senator Roche: I took the core of your answer to my question to be that the poet laureate would contribute to saving society from the overload of confusing images that bombard us. Do you see a poet laureate being able to cut through the mirage of images that defines our era?

Senator Grafstein: Let me put it in political terms. If you think back, what do you remember about political history? I remember Abraham Lincoln: "A house divided cannot stand alone." That was in a way a poetic metaphor. We remember history through pictures, but we remember history equally strongly through simple phrases or metaphors. Kennedy's line, Pierre Trudeau's line about the state

having no business in the bedrooms of the nation -- which holds as true today. That was a brilliant piece of poetry. It was prose that reached the heights of poetry.

We need more of that. We need leaders who help us to understand what is happening around us. Poets help. Robert Frost certainly helped Kennedy to understand what was happening. A poet laureate would help us in Parliament to have a better understanding of what we do.

What do we do? We are not in the picture business. We are in the words business. Sometimes we are our own worst enemies when it comes to words. We have sat in Parliament. I have watched the other House. I am trying to find one great speech a year on the other side, and it is hard to find.

Senator Roche: I hope you are able to find more than one in the Senate.

Senator Grafstein: Yes, and yours, Senator Roche, are among those that reach eloquent heights.

Senator Roche: Thank you.

Senator Callbeck: In the roles and responsibilities section, clause 5 says:

The Parliamentary Poet Laureate shall:

(a) write poetry, especially for use in Parliament on occasions of state;

Will the poet laureate be directed to write certain poems or will it be left up to the poet laureate?

Senator Grafstein: It will be left up to the poet laureate. The poet laureate has a duty, and that duty is to write poetry for occasions of state, if he or she so chooses. I put these provisions in, but I have also indicated in my submission, both in the House and here, that I expect the poet laureate to have minimalist responsibilities. He or she should choose what he or she wishes to do. I am hopeful that that includes writing poetry for use in Parliament on state occasions. However, my requirement, if this bill should succeed, is to allow the poet laureate to do what he or she chooses to do to advance poetry, to give that person a platform in Parliament. The duties of the poet laureate would be minimalist -- for example, sponsor poetry readings, give advice, perform such related duties as requested by the Speaker or the parliamentarian.

The Library of Congress in the United States has annual poetry readings, and they are widely attended. Some of them are quite magnificent. One of the things that Robert Pinsky, the poet laureate of the United States, did was to foster a millennium project, where a hundred Americans would read their favourite poem. It will go into the National Archives. It is a simple, costless exercise, one that will be a magnificent record of the United States in the year 2000; a record about what a group of 100 Americans believe is their inner vision of what is occurring around them.

Therefore, in answer to your question, "shall" means to me, yes, shall write poetry for Parliament on state occasions, but the choice of those occasions, the length of that or the duties are solely at the behest of the poet laureate.

Senator Callbeck: Also in that clause, if you go down to subclause 5(e) -- I do not know where subclause (d) is; it seems to go from (c) to (e) -- it says:

perform such other related duties as are requested by either Speaker or the Parliamentary Librarian.

Will this person be responsible or accountable to those three people?

Senator Grafstein: I tried to blend, as the parliamentary memorandum suggests, several ideas. First of all, the two Speakers in effect make the selection. They are our senior representatives of Parliament. I placed the poet laureate with the Library of Parliament because the Americans have done that and it seems to work well. There would be space there. The poet laureate would be close to books, close to the poetic collection. It is an easy way of dealing with the issue. The Library of Parliament is within the

confines of Parliament. It would be nice to have the poet laureate around.

There are no specific duties sketched out here. I hope the duties will be minimalist. I hope each poet laureate will decide what he or she chooses to take as a priority.

Senator Gill: You do not have any preference for poet, French or English, it does not matter?

Senator Grafstein: No.

[Translation]

Senator Gill: Why would we have a poet laureate and not a painter, musician or someone who is very sensitive to the various facets of life around us, whether we are talking about suffering or joy. I imagine that artists in general have an ability to express things and feel things that the rest of us are more or less oblivious to.

Why a poet? I consider poets to be on the same plane as other artists. Poetry knows how to express things with words and harmony.

[English]

Senator Grafstein: There is a parliamentary tradition about a poet laureate in England. It goes back 400 years. The first one was Ben Jonson, in the 17th century. There is a long and honourable tradition of having a national poet laureate. This same situation applies in the United States since the mid-1930s. There have been dozens of them. Their term there is one year, although some of them have been renewed several times.

For us in Parliament, we do not work in paint. We do not work in music. We work in words. I thought it would be important to have somebody who could help us better express or point us in the direction of a better expression of our ideas. I have no objection to a musician laureate or a painter laureate, but the business of Parliament at this moment and always has been "parole" -- to speak. Nevertheless, if we decided to have a national photographer, a national musician, a painter, I would have no objection.

However, at the heart of what we express, we start with words. That idea is fundamental. We think in words, we debate in words. Parliament is a word factory. So I would start with a poet laureate. However, I am not in any way diminishing what you have to say about other choices or responses. They may be good ideas, as well. As a matter of fact, if you intend to propose that in legislation, I will give it serious consideration.

[Translation]

Senator Gill: On another point, we have had fantastic discussions in the past few weeks on topical issues such as the referendum clarity bill and the Nisga'a bill, etc. How could this poet translate the image that Canada should project and take into account the diversity created by francophones, anglophones, First Nations people and others? How could we find somebody with whom francophones, anglophones and Aboriginal people would feel comfortable and of whom we could all be proud in the same way that we could be proud of our institutions if they were able to meet the needs of all citizens in an equivalent way? Could the poet laureate improve what we are doing in this country? Would he be able to reinvent a country in which our young people, whatever their background, could recognize and feel good about themselves? That may be a lot to ask of a poet. Could this person bring out emotions in us to help us become patriotic Canadians the way Americans are patriotic, regardless of whether our origins are French, English or Aboriginal?

[English]

Senator Grafstein: I do not expect that any one person can encapsulate all the dreams, all the visions and all the issues of unity in one poem or one poet. That is an impossibility. That is not the purpose of poetry. The purpose of poetry is to listen to the words of a poet through their singular vision of how they

look at the country. I would assume that what we want are many different images of the country, expressed through the eyes and words of different poets. I do not think one poet represents all of Canada because there are too many diverse impulses in the country.

What I foresee is a series of poet laureates who will speak from their view. It is an individual art. Poetry, like painting, is not a collaborative art. Therefore, we would hear one voice, one at a time, in various phases, to give us their vision of the world.

I thought you were leading to another problem, that being, how do we reinvent the country? There is a huge controversy in England right now with the appointment of the last poet laureate. His name is Andrew Motion. He is a republican. In England, the government made the appointment a 10-year term. The poet laureate in England is a member of the Royal household; he is paid from the Royal purse. The English poet laureate is given a stipend, and he is given a case of claret on his appointment. Because this recent appointment is a republican, there is a controversy in the country as to whether Mr. Motion was the appropriate selection. How can a republican be a member of Her Majesty's household? However, having thought the issue through, they decided that they need different and alternate voices, which may help royalty become more relevant. Having a republican in the very bosom of Her Majesty's household is one such alternate voice.

Leadership depends on individual voices, leading. Poetry, to me, is a bard in advance, a poet who marches a little ahead of our time, showing us where we have come from and where we should be going. We need different voices. I do not opt for unity of spirit. You and I have common views, but they are different. I look for a civic dialogue. I am hopeful that, by listening to a person's metaphors, I may become more persuaded about their viewpoint. I do not believe in singularity. I believe in diversity.

Senator Keon: I have no questions to ask you, Senator Grafstein. I simply wish to tell you that I think this is an elegant idea. I like your concept of maximum intellectual freedom. One cannot compare poetry and science because they are totally different, and they should be. The great strides that were made in science after the World War II were largely due to the tremendous intellectual freedom given to scientists in the vacuum that was left by the war. Scientists were free to pursue their dreams. I would simply like simply reinforce your concept of the selection of an outstanding poet, from wherever and from whatever background. I am hopeful that he or she will be given the intellectual freedom to express his or her ideas.

Senator Callbeck: Let us assume that we had a poet laureate the last 10 years: On what occasions of state would you have liked to see a poet laureate write a poem?

Senator Grafstein: I would certainly be interested in what a poet would have had to say about the referendum, about the appointment of our last Governor General, about the boat people, about the language bill in Quebec. I would be interested in what he would have to say about the far right in this country, about choice and freedom, which sometimes is being crushed for a lot of different reasons. The poet can choose almost any topic of public or private concern and give us a better insight into ourselves. Read any poet that you love, and you will conclude that that poet allows you to see yourself a little bit more clearly.

I have done some homework on this. A number of our leading parliamentarians were poets. Jacques Cartier was a published poet. He was the discoverer, we think, of Canada. D'Arcy McGee wrote a collection of poetry in 1858. Joseph Howe wrote a poem in 1832, which would be of interest to you, Senator Callbeck, called "Acadia". One of my favourite poems is by Walt Whitman; it is called "By Blue Lake Ontario." It is a magnificent poem about freedom of choice, and so on.

I have purposely refrained from quoting poetry here because I do not want to elevate myself to anything other than a reader.

The one thing I recognize about poetry is that to be a great poet you need a great audience. I hope that if we are successful with this bill, with your help, we will create great audiences for Canadian poets. There are more published poets in Canada per capita than in any other place in the Western World, yet they are unread. They get published, but not very many people read them. I am hopeful that this will be an

impetus for the publication of more and other poetry.

The Chairman: I hesitate to question whether "By Lake Ontario Blue" would be appropriate today -- given the colour of Lake Ontario.

Senator Roche: What is your favourite poem?

Senator Grafstein: My favourite poetry are the Psalms.

The Chairman: Thank you very much, Senator Grafstein.

We will now hear from a panel of witnesses, and our main focus with this panel will be clause 2 of Bill S-5. I believe honourable senators have received a brief by the parliamentary librarian.

In clause 2, the Commissioner of Official Languages for Canada and the Chair of the Canada Council, along with the three gentlemen who are now before us as witnesses, comprise the committee of five that this bill proposes shall recommend a short list. That list will be given to the Speaker of the Senate and the Speaker of the House of Commons.

Unfortunately, the Chair of the Canada Council and the Official Languages Commissioner could not be here today, but they did notify us that they would be sending a letter very shortly with respect to their comments on this bill. Ultimately, we will have heard from each of the five positions outlined in clause 2 of the bill.

Mr. Richard Paré, Parliamentary Librarian, Library of Parliament: I am honoured and pleased to have been asked to attend before this committee. We have circulated a short brief.

Of course, it is not the role of the Library of Parliament to make the case for this bill; nor could we do it better than Senator Grafstein. Our role at the library is to serve Parliament and to provide service to the House and Senate. We are coming from a different angle with respect to this bill.

We note that the bill itself proposes the appointment of one parliamentary poet laureate where we have two official languages, and Senator Carstairs raised the issue. We also note that the bill does not mention any stipend or remuneration for the parliamentary poet laureate. However, we understand that this matter could be addressed by the committee and that it would be the responsibility, eventually, of the two Speakers and/or the parliamentary librarian to address that.

What is interesting is for the poet laureate, being with the library, is that we already have the mandate to disseminate information on the Parliamentary Internet site. We also answer responses to inquiries coming from the public. We also provide visitors and educators with special information and documentation. In that sense, we publish booklets about Parliament. As you are aware, we also run programs such as the Teacher's Institute on Canadian Parliamentary Democracy. The fifth program is coming up this fall. We also have some other programs, like the Centre Block Theatre. We believe that the parliamentary poet laureate could benefit from the library collections. In addition, the Parliamentary Internet could, in turn, be used by the parliamentary poet laureate to reach out to Canadians of all ages. We have the mechanism to allow this poet to reach out to the population.

If this bill were adopted, I would certainly ask for the support and cooperation of my two colleagues at the National Library and the National Archives to give the poet laureate access to their collections.

The only thing I will say with respect to the bill itself is that we believe that it is in line with the general direction given in the last Throne Speech, which indicated that across this country Canada's culture comes alive through all writers, singers and performers. The government's mission is to bring Canadian culture into the digital age. The Library of Parliament can support that with this project.

In conclusion, if the bill is adopted, the Library of Parliament will be happy to administer this new activity.

Mr. Ian Wilson, National Archivist, National Archives of Canada: Since the establishment of the National Archives in 1872, the National Archives with the National Library and the Library of Parliament has been preserving the literary heritage of this country, and that includes the papers of many Canadian poets, the records of The League of Canadian poets, and the records of the Canadian Writers' Association. We do this because we believe that, with the records we have of Parliament, of prime ministers, of senators and of many other statesmen in this country, our literature and our poetry is vital to our well-being as a nation. It is integral to our cultural landscape. It is a central dimension of our intellectual framework. At its best, poetry can be an expression of our dreams and ambitions of our nations.

Thomas D'Arcy McGee published a book of poetry in 1858. In the introduction to that book, a decade before Confederation, he commented that "we shall one day be a great northern nation and develop within ourselves that best fruit of nationality, a new and lasting literature".

I would note, as well, that several of the group that was known as the Confederation Poets were actually employed within the government and were allowed to continue to do their work as poets -- Archibald Lampman, working in the Post Office, William Wilfrid Campbell, who was working at the National Archives, and Duncan Campbell Scott, who had a distinguished career as a poet and eventually Deputy Superintendent of Indian Affairs. They were supported by the state and encouraged to pursue their art and craft.

I would note as well that, in the mid-1930s, Dr. Lorne Pierce, a distinguished publisher, head of the Ryerson Press, who encouraged a whole generation of Canadian writers and poets, commented that "Canada was not discovered until our poets found it, nor was this land explored until our poets made it known." Our poets express and provide for this land a vision, some understanding and self-knowledge, as we face the challenges of the future.

In terms of this specific proposal, the appointment of a poet laureate, the process of choosing a poet laureate, could be turned into an exciting opportunity to promote public awareness of poetry, to develop appreciation of our poetry, and to establish links with those who are interested in improving illiteracy. It would be a great opportunity to highlight and showcase our poets and their contributions to our national life.

From my point of view, as national archivist, both I and my successors would be pleased to have some role in helping select and nominate a candidate for consideration by the Speakers of the two Houses.

[Translation]

Mr. Roch Carrier, National Librarian, National Library of Canada: It is an honour and a great pleasure for me to be here with you this afternoon.

[English]

A long time ago, when I was a young poet, I remember getting together with other unpublished and unread poets, and we would talk about those great countries that supported their poets, France, England. In England, they had a poet laureate. We were dreaming about that. Therefore, I just cannot believe that this afternoon I am with you talking about the possibility of having a poet laureate in Canada.

This country has hundreds of poets, poets that are writing good poetry, poetry that is being read all over the world. It would be wonderful if Ottawa gave them some recognition, in the person of a national poet laureate.

Poetry Day was March 21. UNESCO, the Canada Council of the Arts and National Library of Canada got together to declare World Poetry Day. It was an important event, and I believe that those three players at least should be involved in what is coming for the future. On that day, the National Library of Canada announced the Canadian Poetry Archive on its Internet site. That site will feature the poetry of 100 early Canadian poets. Some of those poems will be recorded so that those who are visually impaired will be able to hear the poetry.

In that context, the business of selling poetry books has been quite good for the past 10 years. Sales of English-language poetry books have increased by 37 per cent. There is certainly some interest in poetry.

What is poetry? Senator Grafstein spoke well about that. To me, poetry is an instant, and in that instant you have the past, the present, and the future. If you read Canadian poetry or Quebec poetry of 20 years ago, you will be able to identify lines of development. Reading poetry is a great way to know the future. Hence, a little bit of poetry in Parliament could be quite interesting.

I was taught how to read statistics and balance sheets. However, when I visit a country, I read the poetry of that country and it provides information that neither statistics nor essays can give me. It is an important instrument for knowledge. In Parliament, there are speechwriters. Why not a poet laureate? It is a step above. It is the next level.

If Bill S-5 passes, the National Library of Canada will be there. What can we offer to the poet laureate? Certainly, the best collection of Canadian poetry in Canada. We have an important collection of archives. The National Library of Canada would offer a safe place to deposit his or her manuscripts. We could also provide some space on our Web site for what is being written. We could provide a place to work, because a poet needs a chair and table. We will support, as much as possible, your decision, if it moves in the sense that I hope it will.

There are other issues in the bill, but they have been addressed by Senator Grafstein.

[Translation]

I do not believe that any poet in Quebec is going to be champing at the bit to become the poète officiel. You really need to find a different translation. The Chair of the Canada Council may agree with me. You would have to ask him.

Senator Gill: It is not poetic?

Mr. Carrier: People will be running the other way if we keep the title as poète officiel.

[English]

Of course, it is impossible to translate poetry. However, in Canada we have developed a unique savoir faire in translating poetry; for example, Dr. Scott's translation of Anne Hébert. We not only have competent, but very inspired translators. We are doing a great job in that work, so I do not see a major problem.

Of course, a poet cannot live on poetry alone. We must address the issue of remuneration. We have good friends at the Canada Council, and there are already some programs moving in that direction. We must address the issue of who will be the owner of the poet's work. It is something that we must address, especially in light of Web site issues.

Overall, however, I believe that the role of this poet, what is called in the bill "other duties," should include promoting. Finally, we can also offer for readings the best medium-sized theatre in Ottawa. It will be available for poetry readings.

Honourable senators, the National Library of Canada strongly supports this bill.

The Chairman: I would like to get back to the question about whether there should be one or two poet laureates. I notice that Mr. Paré, in his remarks, slid carefully over the issue by making the statement: "We note that the bill itself proposes the appointment of one parliamentary poet laureate where we have two official languages." You leave that issue hanging there, which I assume is because you did not want to take a stand on it.

However, it is important for us to understand where each of you, as individuals -- and not necessarily in

your role as, say, parliamentary librarian -- stand on the question of whether there should be two poet laureates at one time, or whether the tradition should be one of alternating every two years between poets of the two official languages. How shall we handle that problem?

Mr. Paré: If only one parliamentary poet laureate is to be appointed, the committee should look into it and establish certain guidelines. If the bill is adopted, the legislation will be in force for many years. There need to be guidelines established. If the decision is to appoint two poet laureates, there would need to be guidelines with respect to those appointments.

We know that, in other appointments, sometimes there is an alternate. Perhaps this alternative might be considered by the committee. I cannot presume the work of the committee. The committee will look at different options and arrive at a satisfactory decision.

With respect to what Mr. Carrier said about our translation capacity, I totally agree with his comments on that. We have inspired translators.

The Chairman: I am not surprised that, if it can be done, Canadians can do it; I am just surprised that it can be done at all.

Mr. Carrier, where are you on the question of one or two, simultaneously or alternating?

Mr. Carrier: Based on my personal experience, Canada is a huge country still to be discovered. I used to say that if we are united, we are united very often by our ignorance about one another. In that frame, again, based on my experience, there is a great opportunity for a poet belonging to one culture to be exposed to another culture and to different cultures.

I do not see this poet laureate as being tied to Parliament. I would like this poet to explore the reality of Canada. It will be fascinating for a poet of one culture to speak about the experience of being exposed to another culture. For that reason, I see only one at a time.

Mr. Wilson: Ideas on this subject have been expressed very well. There are two languages, but there are many cultures. We will need to reflect that in the appointments of the poet laureates. There will be interest certainly amongst our aboriginal peoples wanting to work in their languages as well.

It is my hope that the committee that is involved in the selection will factor that in. In a given time and in a given way, we do seem to make it work. I would support the approach of one individual at a time, but sensitive to the many needs and requirements of Canada.

Senator Callbeck: The bill says that the Speakers of the Senate and the House of Commons will select from three names given to them by a committee. What are your thoughts on the selection committee? Do you feel there should be any other representatives on that committee?

Mr. Paré: You have very good representation on that committee for the selection of such a parliamentary poet. I do not have any special comments. There could be others, but I do not know who they would be. There is good representation, and I believe the committee can do the work.

Mr. Carrier: I would suggest you seek advice from the Canada Council for the Arts on that issue, because they have a lot of experience in establishing selection committees in the arts. Perhaps it would be interesting to seek their advice.

The Chairman: Thank you for attending here today.

Our last witness is Professor Roger Nash. Professor Nash is a professor at Laurentian University in Sudbury. A few of your suggestions, Mr. Nash, relate to implementing the bill. What should the selection process be? Should it be the way it is described here, or should there be modification?

Mr. Roger Nash, President, League of Canadian Poets: I am honoured to be speaking to you. You already have poets in place in the Senate. That is obvious by listening to the proposal of this bill and

some of the other speakers here.

First, should there be one poet laureate as is proposed at present in the bill, or two? I can express my view as an individual here representing most of the League of Canadian Poets, and in a way repeating previous speakers. We are a country of great diversity, but we are one country. We have mountains and plains, but we are one country. We have two official languages, plus Cree, plus Ojibway. We have poets of worldwide reputation who are Canadian, but who are writing in Hebrew, Greek, Spanish. One of the guidelines for selecting laureates might be that, over a period of 10 years, the different languages so richly and vitally present in Canada be represented, that each have its place in the sun over time, that there be only one laureate at a time because there is one country and one prime minister.

Another point was the nature of translation in Canada. We are a world leader in many ways in very subtle translations from one language, one culture to another. I agree with the speakers who say that you cannot really translate a poem and all its inner meaning from one language to another. You create another language if you translate a French poem into English. If it is a good translation, you will have a second good poem -- it will now be in English, it will bear a family resemblance to the first poem, but it will now be at home in a second language.

The ability of our translators is one of our strengths as a culture, because translating is a way of reaching out in empathy from one language and one culture to another, not becoming identical with the other culture, but shaking hands with it. If it is a good translation, it will be an intimate handshake. It is not a black hole in space for Canada.

Previous speakers mentioned that a stipend has not been mentioned in the bill. I presume that that issue will be dealt with at the implementation stage. However, there do seem to be official tasks attached to the role of being poet laureate. It is like a national writer in residence. I would recommend that there be an appropriate stipend attached to the post.

I would recommend, on behalf of the league, too, that although literary merit should be the prime criterion for the laureate some consideration should be given to public relations skills, however you label it, the ability of a poet, not just to be a fine poet but to be an ambassador of Canada both abroad and within the country. I do not see any difficulty in both criteria being met. You can find many people who are excellent poets and very skilled in listening to other people and responding to them.

Those are the main points in the previous discussion that I wanted to comment on.

The Chairman: The stipend issue would never be in the legislation anyway. If an official position were to be created, there would be a stipend attached to it.

Second, I am a little surprised there is a clear and unanimous view of all the witnesses that, at any given time, there should be a single, not a "two-headed," poet laureate. That is helpful.

On point two of your implementation suggestion, you have a sentence that states that writer's organizations have been consulted. I would like to pick up on Mr. Carrier's comment earlier, which was that perhaps we should discuss with the Canada Council for the Arts the selection process they have used over the years for selecting literary leaders in the country. They have a lot of experience. From his point of view, they have been reasonably successful at selecting the right kind of people. Would it be your view we ought to talk to the Canada Council to receive their insight on the selection process? Have you and your colleagues been reasonably happy with the decisions they have made over the years, in terms of selecting skilled people?

Mr. Nash: My recommendation on behalf of the league was that writers, poets, perhaps through their organizations, but in some way at some level, be consulted. Most of the members are generally very pleased with the policy, the practice of Canada Council, because embedded in it is a very important value, that poets like craftsmen of any kind be judged by their peers. What makes a good bricklayer? Other bricklayers will have insights on bricklaying that a philosophy professor will not have. At some point, juries of poets pick who might be nominated for grants in the Canada Council. This is an informed and good way of doing things, much better than having some political manifesto decide who may be

selected. It is a way of doing it at arm's length from political parties.

The Chairman: Senator Grafstein used the phrase "the best poet in Canada," and it did seem to me that "best" is inherently a value judgment on which an awful lot of people could disagree. What you seem to be suggesting -- which would accord with my own peer group review, having been an ex-professor myself -- is that you can determine "best" by having a group of peers in the same field develop a short list, six or ten names for discussion.

Is it your view that the members of your association would be happy if the long list -- rather than the short list referred to -- was developed by the same kind of peer review process that the Canada Council uses?

Mr. Nash: I believe so. The long list need not be developed only by consulting poets, but that poets be included in the consultation process. This process is not dissimilar from the process for government funding of scientific research: Which is the best research proposal is a value judgment, and scientists will want other scientists involved at some stage in some kind of review process to determine which scientific proposals go ahead.

The Chairman: Professor Nash, thank you for being here today.

We will have another meeting on this bill. The date has not been scheduled because we are arranging a teleconference with the Poet Laureate of the United States. It is a question of meshing his schedule with the committee schedule.

On the basis of today's evidence, although the head of the Canada Council has agreed to write us a letter, I would feel more comfortable if the head of the Canada Council would come before us and talk in some detail about the peer review process, which would lead to the development of what I called the long list a minute ago.

The committee adjourned.



Français

Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology

Issue 11 - Evidence

OTTAWA, Wednesday, April 5, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill C-13, to establish the Canadian Institutes of Health Research, to repeal the Medical Research Council Act and to make consequential amendments to other Acts, met this day at 3:45 p.m. to give consideration to the bill.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Honourable senators, we thank our witnesses and everyone involved for their cooperation in terms of scheduling on such short notice, including having one of the witnesses come in from Vancouver.

Our first panel is composed of Dr. Henry Friesen, Mr. Peter Glynn, Ms Maria Knoppers, Ms Janet Halliwell and Mr. Ian Shugart. I bid you all welcome.

Dr. Henry Friesen, Chair, Canadian Institutes of Health Research Interim Governing Council; President, Medical Research Council of Canada: Honourable senators, you have before you today Bill C-13, an important and significant piece of proposed legislation. Research, particularly in health, affects all our lives and is the basis of progress. That progress can be measured in many ways, particularly if one takes a somewhat historical perspective.

There is currently the same number of hospital beds in British Columbia as there was 30 years ago. The management of Canada's health care system has benefited greatly from progress made through research. Indeed, I would assert that without that progress, Canada's health care system would be in jeopardy.

Bill C-13 represents the hard work, discussion and consensus that were forged throughout the last year and a half by the research community and beyond. It is the product of a unique process developed latterly by the interim governing council. The members of this council were appointed by the Minister of Health and consist of representatives from a range of constituencies including researchers, university presidents, the voluntary sector, federal and provincial agencies, and the private sector. We produced recommendations that are the basis of this bill. It is a new way, I suggest, of writing legislation.

Bill C-13 will have a transformative impact on health research in this country. It will modernize Canada's health research enterprise, building on the platform of excellence created over 40 years by the Medical Research Council.

The scale and scope of the bill are breathtaking and historic. It is truly transformative in several dimensions, such as the organizational reach. Bill C-13 will, for the first time, allow systemic input from

a wide range of sectors. The voluntary sector, including interest, community and consumer groups, will contribute to the policy-making advice through the various institutes that will be created. That is a powerful voice and a new force.

Consider the representatives from the voluntary agencies, who in turn represent thousands, indeed millions of Canadians and their aspirations, hopes, interests, and now provide representation in forming and shaping the health research priority and the timetable of the new entity.

Bill C-13 is enabling and facilitative. That is important because science and understanding change. It would be very difficult to write in prescriptive language the undertakings for research that would drive the agenda for 20 or 30 years from now. No one has the foresight to imagine the scale of changes that will occur.

The objective of CIHR is clearly stated in the bill. It is singular and deliberately stated -- to excel according to internationally accepted scientific standards in the creation of new knowledge -- which is insufficient by itself. Unless that new knowledge is translated into improvements to the health of Canadians, strengthening the Canadian health care system, and seeing the development of new products and services, it would be incomplete. The return on the public investment in that translation is improved health. That is a key statement in the objective. Therefore, creating new knowledge, investing in research, supporting our best and brightest, and creating the sort of environment that gives real meaning to the Prime Minister's statement in response to the Speech from the Throne, indicate that Canada will be the place for the creation of new knowledge in the 21st century. That is the goal that this bill will achieve.

Not only improving health care services, but also creating an economic opportunity for this country is an important dimension. It has often been misunderstood. This bill is not to allow investment in support of the private sector, but rather to support academic research that will, inevitably, deliver new ideas and products. These will be developed for the benefit of all Canadians and the Canadian economy by creating new jobs in this country.

For example, it was not long ago that one of the star researchers at the University of British Columbia received a small grant to develop new chemicals that would be helpful in treating macular degeneration, the leading cause of blindness in people over the age of 50.

Today that company is a \$6-billion capitalized company. It is the largest bio-tech company in Canada and has created jobs for the best and brightest coming out of our schools. This, in turn, will affect the health issues in our lives. In the process, this company will create wealth that will, in turn, provide the tax base that will support CIHR.

Already we have begun to see the change in perspectives that is part of the transformative nature of CIHR. Several charts, maps of Canada, that were handed out indicate that before CIHR, we had a localized, often geographically based research enterprise that was unlinked. The CIHR is to create an integrated vision for health research. That vision includes fusing the best, creating networks of opportunities, linking community interests, linking researchers, and seeing Canada mobilize and galvanize its best minds in support of research that will affect the lives and the health of Canadians.

In the first programs, 1500 researchers who were linked to communities and their interests -- district health councils, women's health groups and various other groups -- combined their efforts to help set an agenda. In another program, interdisciplinary health research teams were forged. As well, almost 1,500 Canadian scientists chose to come together in various ways to forge an agenda that would affect the health of Canadians. That is just the beginning.

The activities that have been unleashed by CIHR, once fully operational, will fundamentally transform the Canadian health research enterprise. There is an excitement about this bill, and I, along with my colleagues, look forward to addressing issues and answering your questions about Bill C-13.

Mr. Peter Glynn, Member, Interim Governing Council, Canadian Institutes of Health Research; Chair, External Relations Committee, Heart and Stroke Foundation of Canada: Honourable senators, it is a

pleasure to appear in support of Bill C-13 as a member of the interim governing council. I am also on the board of the Heart and Stroke Foundation of Canada, which is the largest funder of cardiovascular research in the country. As well, I am the President and Chief Executive Officer of Kingston General Hospital, which is a major teaching hospital affiliated with Canada's research-intensive Queen's University, where I see, on a daily basis, the impact on health that research can achieve.

I will talk about three important themes in the bill: partnership, commercialization and knowledge management.

In 1998, the Prime Minister said, "If you invite me back four years from now, I hope to be able to say that your government helped make the transition to a knowledge-based economy and took the steps necessary to keep the best and brightest in Canada." These challenges require a partnership at all levels of government, the private sector, trade unions, the voluntary sector and non-governmental organizations. We must all work together.

Partnership is important to CIHR because its legislative mandate and mission require it to be more than a granting agency. It must become a coordinator, a consensus builder, a facilitator of change, a catalyst, an ethical adviser, a clearing house of authoritative research and information, and a powerful voice for Canadian health research. Partnerships are the foundation on which CIHR will build to meet these challenges. These partnerships will assist CIHR in achieving the objective of selecting and supporting excellent basic and applied research in health sciences, clinical applied research, health care systems, and the social, cultural and population dimensions of health. They will help strengthen and deepen research efforts, building a critical mass of expertise to focus on vital research areas; they will increase the rate of dissemination of knowledge to the various communities with an interest in health and health care delivery, leading to better health policies and practices; they will help find swifter applications of CIHR-supported research results through partnerships with health care providers and health care systems; and they will assist in building bridges between the public and private sectors to encourage the effective translation of research results to benefit Canadians. As Mr. Friesen indicated, the partnership will capture the economic benefit of publicly funded research and contribute to the creation of jobs and wealth for Canadians.

Partnership can mean joining forces with other organizations, sharing funding of research initiatives, or leveraging the funding of other bodies into CIHR projects. It can mean jointly setting research agendas and policies, and working together to improve the understanding of the public on important health issues. Partnership can be cooperation in getting research discoveries and new technologies into practice and use. It can also mean encouraging the collaboration of Canadian researchers across sectoral, national and international boundaries, and between different disciplines. I expect that all CIHR institutes will be involved in appropriate partnership activity. I believe they will be expected to report annually on their successes and the results of their partnership activities to the governing council of CIHR.

The second theme is commercialization. The investments of federal governments in health care are intended primarily to improve the health of Canadians and the functioning of the health care system in Canada and around the world. However, the breakthroughs and the new knowledge generated during the course of CIHR-funded research projects, can and will lead to opportunities for new commercial products, drugs, diagnostics and methodologies. CIHR will encourage the commercialization of these opportunities within Canada to the benefit of Canadians. CIHR will encourage the exploitation of Canadian discoveries worldwide. This will be done in a manner that is consistent with the principles of academic freedom, peer review, wide dissemination of research results through timely publishing, and the public good through public expenditures.

On the topic of knowledge management, as Dr. Friesen has said, there is an emphasis in CIHR on the application of research results. This is a new feature.

Knowledge management means ensuring that the results of research are accessed by all relevant constituencies, professionals, the public, and government, and that they are an integral part of the research process. It means ensuring that the knowledge is shared within and between the institutes to increase a synergy amongst researchers and research. It means the utilization of relevant external knowledge to inform CIHR knowledge and knowledge production, and it means working with groups

who currently disseminate health research information to various audiences.

The end goal of all research is to translate findings into knowledge that will improve the health of Canadians and of people all around the world.

Ms Bartha Maria Knoppers, Member, Interim Governing Council, Canadian Institutes of Health Research: Thank you for this opportunity. Mr. Chairman, honourable senators, I will try to be brief. To the best of my knowledge, this piece of proposed legislation is an historical first. You will note that not only the preamble exhorts legislators and Canadians to take ethical issues into consideration, but that there are three substantive articles on ethics in the bill.

Paragraph 4(e) speaks about promoting and undertaking research at the highest international standards of excellence and ethics. Paragraph 4(g) addresses fostering the discussion of ethics, as well as the application of ethical principles to health research. Paragraph 5(d) addresses the need to monitor, analyze and evaluate issues, including ethical issues pertaining to health research.

If it is an historical first, it will be the first time ethics have been addressed, not only in the preamble, but as an imposed, substantive legislated duty. If this bill is approved by Parliament, how can the challenge be met?

The CIHR created a subcommittee, which I had the pleasure to chair. We undertook a consultative process with partners already in place from a wide array of organizations in Canada, such as the Canadian Council on Animal Care, the Canadian Biotechnology Advisory Committee, and the National Council on Ethics in Human Research, as well as the various bioethics researchers and institutes across Canada.

We have come up with the following proposal as a way to implement the challenge of this proposed legislation. First, rather than creating a specific institute, we thought that the issue of ethics was so central that it should be integrated throughout CIHR.

How do we propose to do this? There would be a committee on policies and procedures within CIHR itself. There are very important ethical issues to do with conflicts of interest, commercialization, integrity, safety, that go across all institutes. We need an internal, coherent policy that would guide all researchers, no matter in what field, and no matter where they are working and with whom. The policy would need to cross national boundaries. This gives them tools with which they can talk to other researchers, negotiate with companies and universities, and so on.

Second, we also wanted to establish an advisory committee within the CIHR. We do not have a national committee on ethics, as other countries do. We wanted an advisory committee on some of the macro-ethical issues, some of the more philosophical yet very important issues that are neither research nor discipline specific, nor even animal or human specific. Examples of these types of issues include obligations to future generations, allocation of resources, and possibly even global bioethics, if one day we can recapture our world leadership in terms of international obligations.

To underpin these two structures -- the policies and procedures committee and the advisory committee -- we would require a strategic initiative called the "ethics office". This would be both a clearing house and an information-dissemination centre, as well as a way for researchers across Canada to have a place of contact not only within their own institute, but outside of CIHR as well.

Each institute's advisory board, as well as the governing council of CIHR itself, would be required to have persons with ethics expertise as part of their membership. Furthermore, proposals going through peer review would be required to take ethical considerations and applications, present and future, into account.

There would also be a specific budget for ethics scholarship. There is a great debate in the country right now in the ethics community about whether we are only of service to different research endeavours, or whether we constitute a separate discipline. We question whether we should be moving research forward, or even slowing it down at certain points.

To that end, we suggested that the future governing council dedicate 5 per cent of its research budget to health ethics research. In other words, there would be a dedicated budget that would ensure that ethics would not be an add-on, would not be a cover-up, but would be an integral part of research within CIHR.

We propose that ethics be central and integrated. Should our advisory committee come into existence and do its work, ethics should be prospective. It should not be only reactive, as we see every week in the news, but actually thinking ahead of scientific advances in order to prepare for them, or even to discuss whether we should be going in certain directions, and the allocation of funding to where the priorities should be.

Finally, I know that the current interim governing council has made ethics very central. It is and has been heartening for me to work with a group of individuals who are committed to that. When CIHR has both central and integrated discussions on applications, implications and prospective ethics, we can begin to meet another level of obligations, to the international community at large. It is my personal view that Canada has a lot to offer the world in terms of global bioethics and CIHR is a starting point.

Ms Janet Halliwell, Director, Corporate Liaison and Innovation, Social Sciences and Humanities Research Council of Canada: Honourable senators, I am pleased to be able to appear before you in support of Bill C-13. I am wearing two hats. I appear on behalf of Marc Renaud, the president of the Social Sciences and Humanities Research Council of Canada, and as the co-ordinator of the institute design and creation activity, working very closely with the one of the co-chairs of the interim governing council and the members of the council itself.

I will be talking about two things. First, the role of the social sciences and humanities within CIHR, and second, the issues of institutes.

From SSHRC's perspective, and that of the community we represent, the creation of CIHR is an enormously important and exciting opportunity. The bill sets out a vision of an integrated health research agenda that crosses disciplines and explicitly includes social sciences, humanities, and the health systems and services.

How large is the community of researchers who will contribute their talents to the health research agenda? This time last year, we could not answer that question. We now know that there are over 100 institutes with a major research thrust in the social sciences and humanities, or health systems and services. There are over 2,000 active researchers today, as well as many others who would deploy their talents to this area of endeavour.

There are individuals and groups who would recognize the potential to bring their disciplines -- sociology and theology, law, psychology, management, linguists, as examples -- to bear on health problems and issues.

An integrated research agenda is not simply a future dream. As Dr. Friesen has indicated, the last year has brought many new partnerships and networks across Canada among the diverse research communities. New partnerships have been founded in the development of institute proposals, in the development of slates of institutes, and in the development of programs that would allow the communities to work together, as well as in the responses to those programs.

It has not been just a collaboration forged within the research community itself. There have been bonds built between the staff of the Medical Research Council and the Social Sciences and Humanities Research Council. There is mutual respect for very different scholarly activities, traditions, and approaches, but also mutual commitment to the objectives of CIHR and to rigorous peer review.

Most important for the community, CIHR means an opportunity to expand the range of research on a broad set of health questions to examine such things as the links between health and health status, on one hand, and human behaviour and social and cultural processes on the other.

I will give just one example to indicate why we must move beyond the dramatic successes of

single-discipline research, which will continue to be a dominant element of our activity. Many complex health problems are interdependent in terms of the social, behavioural, and biological processes that influence them. Research across disciplinary lines that integrates various levels of analysis represents one of the huge frontiers.

For example, the prediction of coronary heart disease considering only one set of risk factors would be insufficient to explain the variance in that disease. We now know that we must work in the areas of socio-economic status; social support; behavioural, including physical activity and smoking; and organ, such as low-density lipoproteins and hypertension, to explain variances.

This brings me to the most important element; that is, how to create an environment in which researchers will rub shoulders with and benefit from the wisdom and insight of others. This is, of course, the opportunity of CIHR, the community of the institutes, and the related structures that are part of it.

The institutes are certainly the key instrument to propel CIHR past the vision of the traditional granting council. You have access to the interim governing council papers on institute design, so I will not reiterate what is there but only highlight the fact that the institutes are virtual. They will have a scientific director and scientific advisory boards that will provide them with guidance and the linkages with their partners in the community and other health stakeholders.

These institutes will function as unique focal points of leadership, participation, partnership, and priority-setting. However, any one institute does not exist in isolation. Rather, it is part of a larger landscape of institutes that provide an appropriate home for a full spectrum of health research and an effective balance of activities among disease and health, prevention and cure.

Equally important, institutes are only one among a portfolio of mechanisms in CIHR. They exist within an interactive and adaptive system of programs, peer review systems, partnerships, standing committees of CIHR, and offices, each of which will ensure a critical focus on an important element of the health research agenda and the modes of doing research.

Consider two of those structures very briefly. With regard to offices, as Dr. Knoppers mentioned, ethics is a prime candidate. These are designated focal points in the secretariat for specific strategic issues and priorities that transcend institute mandates and where there is need to ensure that those issues permeate all of the institutes.

Standing committees will be created by the governing council for many activities. Some will centre on core corporate functions, some on critical policy initiatives such as ensuring the effective inclusion of the major sectors of health research in each of the institutes and their continuing health. They may focus on how best to develop strengths in under-represented areas and to nurture future institute proposals.

I will say a few words on institute creation. There is currently at work a subcommittee on institute creation that is examining what sort of advice it can give to the governing council on the overall shape of the institute portfolio within CIHR. It has articulated a set of criteria and parameters for the functioning of those institutes. One of those is that there would be no more than 10 to 15, and that the institutes would be broad. Clearly, we will not be able to have an institute for each of the major health issues within Canada, so we are looking at creative groupings.

The subcommittee started consulting with Canadians last fall and received over 80 very significant submissions that revealed an incredibly rich interest in where CIHR was going and a high degree of convergence. The response was overwhelming, both in number and in the richness of thought and activity. Many of the responses incorporated consultations of hundreds of researchers and stakeholders behind the paper that was produced.

There was significant convergence on many issues, including the need to maintain fundamental research excellence within the institutes while focusing on health issues for Canadians, the importance of adaptability and flexibility of the evolutionary nature of institutes, and the need to establish a mechanism of interaction among institutes in order that they will not sit as silos.

The subcommittee is in the process of incorporating and evaluating this input. Some things are clear at this stage, including the fact that there is no unique organizing framework for the institutes, that there are valid and appropriate approaches in such areas as studying disease, health issues, human physiology, and stages of the life cycle. It is also clear that there are a number of very specific strategic initiatives that require the particular attention of the governing council. They include ethics; aboriginal health; rural health, which affects one-third to one-fifth of Canadians; and women's health.

In concluding, I will use women's health as an example of how the subcommittee and the interim governing council are seized with the importance of gender and sex as variables in health research. Achieving the CIHR objective will demand effective consideration of this, but whether that will translate into an institute specifically focused on women, or some other structure, remains to be determined. It is indeed one mechanism, but even with an institute, cross-cutting structures would be required for effective integration throughout CIHR.

A strong office embedded in the corporate structure could provide strategic leadership and daily interaction with a peer review system. Program structures and standing committees could be integrated into an adaptive system. This is true of all of these special areas that must be looked at. The interim governing council will be looking at how best to balance these and provide some insight as to how they could be shaped into an overall, functioning CIHR. Certainly, future evaluations of CIHR will be looking at how well it performs on those dimensions.

I wish to reiterate the extent of the support of SSHRC for this initiative and the fact that we will continue to be a partner in the years ahead for CIHR.

Mr. Ian Shugart, Assistant Deputy Minister, Health Canada: Honourable senators, it is now widely accepted that an integrated approach to health is essential to creating healthy individuals and communities. In order to accelerate discovery, we have to broaden what we know and apply it for the benefit of Canadians and contribute, directly and indirectly, to more effective health care for Canadians. As you have heard this afternoon, research is needed from several perspectives, and often in combination from these four areas that CIHR brings together for the first time systematically in Canada: biomedical research; clinical research; health services and systems research, which deals with understanding how services and systems are organized and how these things can be delivered more effectively, what works and what does not; and research on the determinants of health within communities and populations.

This afternoon I want to provide a summary of what you have heard, and also the perspective of the Minister of Health and Health Canada. The CIHR legislation, as it is proposed, explicitly embraces the range of approaches to health research required to achieve improved health outcomes for Canadians, and it is outcomes in which we are really fundamentally and ultimately interested.

It is important that you know that Health Canada, and indeed other departments of government, will be a key partner and client for research evidence generated by CIHR. It is our job to ensure that research evidence is well utilized in the health policy dialogue, which I know will be of particular interest to this committee in the days ahead, and in turn that gaps in knowledge and information are identified, articulated, and addressed by appropriate research mechanisms.

I am not speaking of command and control science, I am speaking of identifying problems. Fundamental to the research enterprise is identifying the question that is important. Health Canada sees its role, in part, as contributing to the identification, the articulation of questions. Therefore, we take a particular view of the tremendous opportunity that is represented by CIHR.

[Translation]

In short, health research today looks at a whole range of matters affecting the population's health. It is based on the intellectual contributions of people working in all kinds of disciplines in sciences, engineering, social sciences and social studies.

As is often the case in matters of health, though it is important to allocate more funds, that is only part of the total solution, which brings me to Bill C-13. The latter gives a whole new vision of health research

through the creation of these institutes.

It describes a modern design that will harmonize far more closely and strategically health research and the Canadian population's priorities in matters of health.

We hope to see a new opportunity for all Canadians to identify with health research.

[English]

It is important that we see an opportunity for Canadians to understand and to see themselves in the research enterprise. That has always been the case, particularly in the work that the voluntary sector does in research, but we believe there is a tremendous opportunity to deepen and to broaden that, and indeed to make the case continuously for how research is fundamental to advances in health.

The bill establishes a research enterprise that will get people from different research backgrounds working together in common cause. The bill will be oriented to the health priorities of Canadians. Third, it will be mandated not just to support research, but to get the results of that research out into the hands of health professionals, other researchers, policy and program officials in government and the health system, including our department, and into the hands of Canadians.

Health Canada is poised to be part of that future enterprise. We are committed to working closely with CIHR as a partner to help to translate the new knowledge that is gained as a result of research into better health for Canadians. We have a particular interest in the areas of health information and health information systems, knowledge management and exchange, renewal of health care, and the science of public health and safety.

The objective for CIHR emphasizes the outcomes that CIHR is designed to achieve through a revitalized health research enterprise that will accompany Canada into the 21st century: a renewed vision of the central role of research in evidence applied to health decisions, these mechanisms that bind researchers and prospectives, provincially, nationally, internationally, both to each other and to the issues that we are addressing. It is important, given Canada's geographic and cultural diversity, that we create an enterprise that recognizes diversity in health outcomes and in approaches to health and disease.

CIHR, in summary, provides an unprecedented opportunity to link health research to national and provincial health priorities and to ensure the effective transfer of research findings to inform policy and programs. Partnerships between the institutes, and a broad range of health research partners, will be important in creating synergies and focusing efforts to increase overall benefits to Canadians. As you have heard, linkages with the voluntary sector, which reflect the involvement, interests and concerns of many Canadians, will be essential to its success.

Our vision for the future of the Canadian Institutes for Health Research is of a flexible, responsive research enterprise that continuously renews itself through the evolutionary process of science, and through partnerships with the broad range of players in health research.

Senator LeBreton: On the linking together -- and Mr. Glynn, in his remarks, referred to all levels of government -- are there provincial agencies or community-based agencies that will be brought under the umbrella of CIHR? Were these agencies consulted by the interim governing council? Further to that question, will any of these agencies be represented on the new governing council?

Dr. Friesen: The immediate, short answer is yes to representation and consultation. Several of the provinces have major research agencies, such as Alberta and Quebec. The presidents of both those organizations were on the interim governing council throughout the last year and participated actively. We have had, over a period of time, a rich collaboration with both of those agencies, as well as some of the smaller ones like the Nova Scotia Research Foundation, the B.C. Health Research Foundation, and the Manitoba Health Research Council. There has been, at an operational level, a very extensive involvement engagement. Also on the interim governing council was the deputy minister of Ontario, who is an active contributor.

There will continue to be, without question, complementarity of positioning, a very healthy collaboration that has existed and in my view will continue and expand.

In terms of appointments, the minister is on record as saying every province will be represented on a governing council.

Mr. Shugart: I wish to add the point that the Ontario deputy minister was chosen to join the interim governing council through a process of being identified by his colleague, a provincial deputy.

There has been a growing attention over the last years among provincial ministers of health to research activity in Canada, and I anticipate that that will continue. Historically deputy ministers and ministers of health have not always focused on health research in their frequent get-togethers. I believe that is changing significantly as there is a greater appreciation of the role that research plays in health overall.

Senator LeBreton: Will the valuable research work of the various agencies in the provinces or communities be tied in? Will it all be tied in under the umbrella of the new agency? I am not sure how it would all be linked together.

Dr. Friesen: Let me try to give you the portrait. In an integrated portfolio of research support in Canada, in order of size, the federal government is the largest. The voluntary agencies in aggregate are the next largest contributor in the public sector. They almost equal the federal government's investment level. The provincial agencies run a somewhat distant third.

There is less likely to be a tightly structured integration than an informal collaboration, both in terms of the various institutions and the scientists in those institutions indicating to CIHR what support they are getting through the provincial avenues. They would be seeking to position their request to the CIHR in a strategic way to avoid the duplication that none of us would support.

Senator LeBreton: Have you looked at other countries? Are there similar institutes in other countries, and if so, as part of your consultative process, did you consult with these countries, or analyze the work that they have been doing? Or are we unique in this?

Dr. Friesen: We have indeed consulted, and quite widely. We visited the National Institutes of Health, which is the U.S. equivalent. It is structured differently but has some similarities. It has a very long history, over 100 years of performance. It is held up as a world standard in terms of scope of investment.

The discussions that we had there were very informative in signalling what works. We discussed the notion that if they had the opportunity to start again, what would they do differently, what changes would they make. That dialogue was most interesting. They shared with us our sense of excitement, reflected back. They imagined how they would proceed if they had a clear slate.

The NIH, a huge private foundation that is endowed at about \$14 billion, is different. It is a network. Again, there were some valuable lessons. It was most instructive to hear how important it was to network and encourage mechanisms to allow scientists from different perspectives to come together. A number of new directions flowed from those interactions.

We also heard from the architect in Britain of the research component in the National Health Service. Through his leadership, the U.K. government directed 1 per cent of their total health care bill for the National Health Service research portfolio. A good example of how they were going to do that was an extraordinarily interesting program with the descriptive acronym of GRIP, Get Research into Practice.

There is opportunity to learn. Bill C-13 describes an important mandate for CIHR to seek and seize international collaboration and opportunity. Science, more than most things, is international. Canada produces approximately 4 per cent of the world's knowledge. That means we can leverage in 96 per cent to our advantage. That is the scale of the opportunity.

Senator Callbeck: I want to ask a question about the provinces. There has already been a question about the relationship between CIHR and the provinces. I want to pursue that a bit because, Mr. Friesen, when

you answered, I think you talked about Nova Scotia, British Columbia, Ontario, and Quebec.

The criticism that I have heard is that the provinces have not been consulted enough. Do you think that is fair? Have all the provinces been consulted? If so, how?

Mr. Shugart: The main forum, if you will, for what I might call formal expression of the views of provincial governments has been through the conference of ministers of health and deputy ministers of health. CIHR has, in fact, been explicitly discussed in those forums. There has been opportunity for questions, and that opportunity has been taken.

Mr. Lauzon, as I mentioned, formally represented his provincial colleagues, all of the provinces and territories, on the IGC. It would be fair to say that he was quite solicitous of his colleagues' views and input.

That would be the formal vehicle for the expression of provincial views. I think the reaction from the provinces, as we would perceive it, has been that this indeed is a tremendous opportunity for the country as a whole.

I think it would be fair to say, and it would be quite understandable, that some smaller provinces, particularly those without medical schools within their borders, would be anxious that researchers in their communities not be disenfranchised from the research activity of CIHR. It is the actual design of CIHR to bring together researchers from a variety of disciplines. That design feature creates a tremendous, new opportunity for those jurisdictions that have perhaps not been substantially involved in health research to become involved. Activity will not be limited to researchers from medical schools.

Technically, it never has been limited. However, there has been a flow of research funding, understandably, to those jurisdictions with medical schools. That is a tremendous new opportunity for social scientists, for those in other aspects of the life sciences, environmental sciences, for example, to be contributing and to be part of the research enterprise.

Dr. Friesen: I have, during my travels, met with every ministry of health and economic development throughout this country, including the Atlantic provinces, including your province.

We recognized that, if we really believed research was important to the health of Canadians, every province should see development of a research capability locally. We put that forward as part of an early phase stimulus. Some of the provinces, which Mr. Shugart has referenced, have not been as fulsome in their development, including Prince Edward Island and New Brunswick. We proposed a regional partnership initiative to kick start the opportunity. That was very well received.

In the case of Prince Edward Island, the president was delighted to see the investment. We have now these stimulus initiatives with Saskatchewan, Manitoba, New Brunswick, Nova Scotia, and Prince Edward Island. These will help us see capacity grow and develop. The initial response has, in the case of Saskatchewan, doubled their research investment through the precursor agency, MRC. Undoubtedly, with CIHR, that will be expanded and flourish even more.

Ms Halliwell: One additional area of consultation with the provinces was in the institute creation activity, during which there were specific letters sent out to the deputies of Health, as well as the deputies of Education, in each of the jurisdictions to be sure that they were aware of the opportunity to provide their insights and input.

We did receive fairly good and substantive responses from about 50 per cent of the provinces.

Senator Callbeck: I have a question on the Centres of Excellence. How will they fit in and what will be the role of CIHR there?

Dr. Friesen: The network of Centres of Excellence is a program with a specific mandate to forge linkages in science with a clear expectation of seeing discoveries developed for commercial gain and benefit. The scale, the scope of those networks, is very modest in comparison with the size or scale of an

institute. I would see the networks actually being an integral part of a CIHR portfolio. For example, if there were an institute of genetics, the network of Centres of Excellence would fit in very well in structure and in support. Indeed, I could see some leadership skills forthcoming that have been forged and developed through the networks program. Those skills could be embraced and incorporated into an institute arrangement.

The Centres of Excellence are part of the Canadian landscape. They have very specific mandates and they will be complementary to the institutes.

[Translation]

Senator Gill: I would like to know what representation was expected and whether it is covered by the bill not only concerning the scientific disciplines or the provinces, but mainly concerning the representation of social groups. You spoke of women and Natives in the different disciplines, but is there anything provided for to ensure adequate representation?

[English]

Dr. Friesen: The bill speaks of appointments of women and men who represent the diversity of perspectives that should be seen as part of an institute. There are several ways of viewing representation on the CIHR structure. One is, of course, at the governing council. Those appointments will be made through a governing council appointments process.

It is instructive to hear what has happened in the first phase of the development of CIHR, in the appointments process that has been endorsed by this government. It is precedent-setting in its openness. There was a public call, with advertisements run for nominations for president and for membership in the governing council. In turn, the government then appointed selection or screening committees drawn from, again, a range of perspectives. There were university presidents and international representation. They looked at the selection of the president and provided advice to the Prime Minister's Office, narrowing down the larger list to a more manageable one, of which the selection committee said any person would be a worthy leader of the new CIHR.

In the case of the governing council, over 400 outstanding Canadians were nominated from all quarters. Again, a selection or screening committee was struck to narrow the list to a more manageable number. Again, the call to the screening committee was to make sure that the objective of CIHR is embraced by the richness of views that will be expressed by the individuals to be nominated, or recommended for possible nomination, to the governing council. Respect was paid regarding provinces, gender balance, linguistic requirements -- all of those normal Canadian considerations.

It is also clear that there is a very new dimension of representation that should be understood, and that is on the advisory boards. For example, if there were ten institutes, each with eight to ten members on the advisory boards, that is a great opportunity to see represented the variety of partners who are integral to CIHR. Those partners will be part of the mandate of one of those institutes.

For example, if there were an institute in the area of hormones, diabetes, nutrition, I could not imagine that individuals who are directly affected by the disease would not be represented on that board, either through a diabetes foundation or through the Diabetes Association of Canada.

On the subject of partnerships, I invite Mr. Glynn to expand further in answering your question about representation.

Mr. Glynn: One of the things that I emphasized was the opportunity for partnership with many different community organizations, with provincial governments, with the health charities, and with the national voluntary organizations, to accomplish mutual aims and goals. I would certainly see an opportunity for community groups, possibly a health charity, to partner with CIHR on particular health issues of concern to them. We are not necessarily talking about partnership here in terms of money. We are talking about partnership in terms of ideas, influence, translation of these research findings into practice, et cetera.

I see this as particularly important, as Ms Halliwell said, when we come to what one could call the social determinants of health as opposed to the bio-sciences. There are many communities -- and the aboriginal community is an important one -- where these partnerships can help form the linkages to actually apply the research results and learn from that application.

[Translation]

Senator Gill: There are doctors, nurses, psychiatrists and psychologists, but do you provide for any Native representation in certain institutes?

[English]

Dr. Friesen: Ms Halliwell referenced the issue of aboriginal health as being of great importance to Canada and Canadians. I could not imagine that one or other of the portfolio mechanisms that Ms Halliwell outlined would fail to engage and involve members of the aboriginal community, most importantly in priority setting, in translation, and in research opportunities. After all, members of the aboriginal health research community perhaps have the deepest knowledge of the concerns of the community they represent.

I believe that aboriginal health is a key dimension that government would expect to see addressed. A wise governing council would recognize that and would seek to implement that at the earliest opportunity and at the highest level. That must, in my view, involve both partnership and representation by members of the aboriginal community.

Senator Cohen: Ms Knoppers, you referred to paragraph 4(e), which has the objective of undertaking research that meets the highest international scientific standards of excellence and ethics.

Are there international standards that are currently accepted?

Ms Knoppers: Yes. As you are probably well aware, that is because it has now entered into the culture of the Nuremberg Code, which was more a reaction to abuses than it was a code for setting ethical standards. This was followed by the Helsinki Declaration of 1964, which has since been amended. Since that time, UNESCO, WHO, the Council of Europe, and the European Community have developed different standards for varying kinds of research that includes areas such as biomedics, epidemiology, genomics, paediatrics, and the more controversial area of reproductive technologies. They are quite active and have been vocal in representing these international endeavours. We, as a country, have not had that high level of productivity and visibility. We hope that CIHR will allow us to do that.

Senator Cohen: The changes are sweeping and it is sometimes difficult to comprehend the magnitude of the issues. Your enthusiasm is contagious.

The Chairman: Did you imply that there is an international set of standards for reproductive technology?

Ms Knoppers: No.

The Chairman: You did not mention cloning. Is there a set of standards for that procedure?

Ms Knoppers: There are various national endeavours. Article 18 from the European Convention on Biomedicine, 1997, specifically states that embryo research shall be limited according to the laws of each country because they were unable to achieve consensus with Germany and the U.K.

In addition, the Universal Declaration on the Human Genome and Human Rights, Article 411, mentions cloning as one activity that would be considered contrary to human dignity. That is a declaration, not a prohibition.

The Chairman: I suspect there will be legislation at a later time on the reproductive issue.

Senator Robertson: Will the issue of standards be addressed and in what manner? Will you be

developing standards of excellence? Will you consider certain international standards? Who will be responsible for the development of these standards of excellence for all phases of research, and how will that be accomplished?

Ms Knoppers: I will start with the ethics. One way to ensure that we do not become insular or too comfortable with the subject ourselves as academics and researchers who work in partnership with communities and different interest groups, is through peer review. Projects, proposals, designs of institutes and so on, are submitted for evaluation by outside experts. Often these experts possess different viewpoints, have experienced different cultures, or perhaps derive from different disciplines, and thus bring new perspectives to the evaluations. That is an enriching process because you never know how high the bar will be. The European continent is extremely rich in both philosophical and ethical tradition, much more so than North America. That does not mean that we are not aware of it, but we do not have similar ethical and philosophical traditions integrated into our culture. That is why it is such an opportune moment.

Dr. Friesen: The gold standard for judging excellence is peer review and the process is used internationally. It is a never-ending effort to reach perfection, but it is a human activity. Therefore, it is inevitably fraught with failure and lapses from time to time. Nevertheless, that is the approach that is used.

In order to ensure that that international benchmark of excellence as reflected by peer review is respected, it is important to have a rich reservoir of talent in the pool of peer reviewers. Currently, in all the granting councils, the processes, while not identical, have a great deal of similarity. In the health research field, we call upon reviewers from all major countries to participate in the peer review, either through written commentary or, from time to time, in person. The truth is, there are many more good ideas than any agency can fund, even with the enhanced funding that is envisaged through CIHR. A good example of that would be the response to the transitional programs that I spoke about. We had 180 proposals and I suspect that we will be hard pressed to fund 20 of them. In order to establish which are the most productive and excellent, a rigorous process of peer review will define the greatest opportunity and the greatest excellence.

Senator Robertson: Will this also encompass the area of commercial health research? Will there be an interrelationship with commerce or does that stand alone? When you receive a product, for example, how will you market it?

Mr. Glynn: We do not see, first and foremost, CIHR owning the intellectual property. Universities have policies on that. However, CIHR should encourage the relationship and technology transfer. A number of universities have excellent technology transfer programs, and in our report on commercialization, there is reference to strengthening those endeavours and the capacity of individual researchers to understand how to move their bright ideas into practice. Also, there are numerous good programs around, such as the Natural Sciences and Engineering Research Council of Canada's technology partnership program, which is one example of a partnership that enables the taking of ideas to the next step. Another good example is the Canadian Medical Discoveries Fund in partnership with MRC to obtain funding through the private sector and venture capital for the actual commercialization of these ideas.

Senator Roche: In respect of international standards, I strongly support your comment that it could be helpful to have Dr. Knoppers back, in a discrete role, to discuss ethics in the long term.

I understand that the internationally accepted standards are the umbrella under which many things in paragraph 4 are permitted to be done.

I understand that these internationally accepted standards are standards on how research is done, as distinct from the ethics of the subject that has been researched. Am I correct?

Ms Knoppers: Most international guidelines, standards, directions, and declarations, unless they are of a legal nature, are worded as principles because they are meant to guide national legislators in making these principles come alive in their own countries. Therefore, these declarations and conventions are at a

level of goals, setting out the purpose, the areas of endeavour where priorities should be set, such as solidarity and collaboration between countries, respect for dignity and diversity, and so on.

If countries that are members of these various international bodies, or even observers, such as Canada sometimes is, adhere to them, then the domestic legislation of those European countries that sign and ratify must be in conformity with the principles.

However, the other type of international directives, guidelines, and so on, tends to be more process oriented in terms of epidemiological research or clinical trials. We have extremely detailed international directives, the international clinical harmonization trials, for clinical trials that allow us to do trials in France, Germany, Canada, and the United States, all following the same process rules that you just mentioned, but those process rules are guided by shared principles. It works hand in hand that way.

Senator Roche: I think I understand that. With regard to what will actually be done, under paragraph 4(e) there is a vast array of research. I should like to concentrate for the moment on what we might call the "life issues". How will this research be done by the Canadian Institutes of Health Research? At the level at which we are operating in Canada, by what criteria will this body determine the ethical aspects of life issues?

Ms Knoppers: That will be determined at two levels. First, Canadian scholars from across the country, particularly in the social sciences and humanities -- theology, health care systems analysis, economics -- will be putting forward their own proposals. There is knowledge throughout the country. You need not be in a bioethics institute or even a research setting to be able to participate in the elaboration of ethics issues from conception to death, including many of the ecosystem, environment, and health services questions that we see in paragraph 4(e). The grassroots researchers are where the strength lies and from where the originality usually comes.

At the same time, we want a systemic approach within CIHR, an infrastructure approach in terms of guiding our researchers, so that those whose proposals do meet the standards of excellence would be bound by common ethics procedures and policies.

As well, we want to encourage self-standing research into ethics itself, not just "service ethics". I do not like that expression because working with colleagues in different fields and disciplines is not just service; it is working together in an integrated way.

Senator Roche: Would it be within the mandate of the CIHR to pronounce on the ethics of certain subjects, that is, test tube babies, palliative care issues, abortion, the moment of conception? These questions are alive and hot in our country. I dare say that many Canadians would be interested in an expression of views on the ethics of these life issues.

Ms Knoppers: One of the structures we proposed was an advisory committee, in addition to the ethics policies and procedures, to review those very important issues about which Canadians are concerned. In the absence of a national ethics committee, we thought this was the opportune time to create a structure that would look at the larger ethical and philosophical issues you have mentioned.

I think that such a committee would be advisory. The government could refer issues that it wanted discussed to it. These are complicated and very topical issues. However, they also call for values in which people dearly believe.

Senator Roche: You do foresee the CIHR giving advice on the ethics of life issues?

Ms Knoppers: Yes.

Senator Roche: I do not know whether I am satisfied with that, but I am probably running out of time. I would like to know more, Mr. Chairman, about who will propound these views.

The Chairman: When we eventually have an institute that deals with those issues, I will be happy to have these people back, as I was implying earlier.

Dr. Friesen: Ms Knoppers has not mentioned that three councils have actually triggered a first for Canada in the world; that is, a tri-council policy statement on ethics as it affects human research. It is all-encompassing research from whatever domain it may be generated. That, operationally, is the framework of ethics that governs research undertakings.

The instrument that rules on the appropriate adherence to those ethics statements in the policy framework are the research ethics boards that are in place in each institution, be it the Kingston hospital, Queen's, or any other. Each research project must pass through that filter of research ethics boards whose composition is defined in the policy statement. That is the ethical safeguard for the research that will be supported by CIHR. In addition, at Ms Knoppers has mentioned, research dealing with the important questions that you have raised could be undertaken under the auspices of CIHR.

Senator Fairbairn: The issues I wanted to hear about are related to your comments on ethics and commercialization. You have, through your answers, thrown greater light on the ethics area, Dr. Knoppers.

My question relates to this area, and perhaps others as well. What built-in communication structure will there be in this operation? I sense your excitement, and I understand it. I hope that that same excitement and greater understanding can be moved through the levels of scientific research down to individuals in this country.

My colleague Senator Cohen said that she felt very unprepared in even discussing these issues with which we as legislators are often bombarded. At the same time, we do not have the qualifications to give advice, answers, or indeed to understand a great deal about it ourselves.

In the whole area, particularly of biotechnology and genomics, we are, as you have said, bombarded in the media every day with reactions. How do we improve the understanding of the issues by Canadians in order to balance that uninformed reaction?

This speaks to personal health. It also speaks to animal health, and the development and marketing of products. We did spend several very interesting months in the Agriculture Committee of the Senate not too long ago on the entire question of bovine growth hormone that became hugely controversial because the public made it so. They did not understand. As it involved milk, there was a negative reaction rather than understanding.

I should like to know about your communications strategy, because your wonderful work must find its final resting-place in the understanding of the citizens of the country.

Ms Knoppers: We see the ethics office -- I am talking about the interim governing council when I say "we" -- as finally providing Canadians with a central clearinghouse for dissemination and transfer of information, and with the ability to have a hands-on approach to some of the work that already exists in this country or some other countries and international agencies. When people ask questions about what is going on, about what have other countries thought and what is happening in Canada, there would be a place that we could call on for information to help discussions on those issues.

I would also like to pick up on the point about the tri-council policy statement. Lest you think that I believe Canada is behind in ethics, let me say that this tri-council policy statement serves as an ethical, scientific and social filter for research that is activated through the research ethics committees who use it to research protocols.

This is a world first, but not because it is an ethics guideline; there are many of those. It is a world first because it actually takes into consideration all the disciplines that conduct research dealing with the human person. Heretofore, an individual would be sent to one committee for social psychology aspects and another for engineering issues and so on. These guidelines would apply to any research involving humans, be it in the area of music, gymnastics, or biomedical. It is a very unique set.

The focus is on the person. The disciplines must get together and share their common ethical filter. In

that sense, we are not in any way deprived here in Canada. On the larger issues, there is a need for a body such as CIHR to pull some of the information together. There is the Canadian Biotechnology Advisory Committee and the Canadian Council on Animal Care. I mentioned in my five-minute presentation that there is the National Council for Ethics in Human Research. All these groups are working together to keep information ongoing and policy-making alive.

The Chairman: We will have to spend some considerable time in our other health care meetings on the ethics question.

I will wrap up with three short questions.

I understood, Mr. Friesen, that in your response to Senator Gill you pointed out some of the unique problems associated with aboriginal Canadians. Ms Halliwell also raised in her presentation some of the unique problems of people living in, I think you used the words "rural and remote areas". Would you please enlarge on that subject? I assume that the nature of the medical problem could occur anywhere. The issue is, how one delivers services in those areas. Is that the aspect to which you were referring?

Ms Halliwell: The subcommittee has been wrestling with issues regarding groups that are, for one reason or another, marginalized in Canada. That marginalization can result in very different implications in terms of health status and health delivery. In rural health, one can look not just at health delivery, but also health status.

Issues of access, of course, are among the most profound. The debates in the subcommittee included the view that this is an area where Canada could become a world leader. We have a special vantage point with our geography, issues of aboriginal peoples, rural health -- tele-medicine would be a good example of how one could actually look at that application -- of multicultural communities and of health status within those.

The Chairman: I have two more questions for Dr. Friesen. First, I am not trying to pin you down on what the actual institutes might be, so this should not be taken as an announcement. However, could you give me three or four illustrative examples of what the title or subject matter of these institutes might be?

Dr. Friesen: First, let me frame the answer more broadly. It was our view at the interim governing council that the issue should resonate with Canadians as being appropriate and reasonable, given their own perceptions about health status and needs. I have always been on record as saying it would be astonishing to Canadians if there was not an institute with a mandate to focus on issues like cancer, heart disease, or some of the important developmental issues that affect health and early childhood development.

Given, particularly, the focus of concern among Canadians about the status of their health care system, we should see an institute that would address these matters in an informed way. Indeed, I would have thought a responsive and flexible CIHR might actually seize the opportunity to be the instrument for Canadians to come forward and challenge the research committee.

It should challenge the best and brightest in this country to determine what new and innovative ideas could be shaped and framed through research to assist Canadians in understanding that their health care system can be strengthened. There are health services, population health issues, and issues related to specific diseases that are of huge concern to Canadians. Those are the kind of issues that should be embedded in and expressed in an institute structure.

The Chairman: I have one last question, where I am playing a bit of a devil's advocate. As a former academic, and having been subject to the peer review process a number of times, the one thing that has always bothered me is the difficulty in getting that process to accept unique and different ideas. The example I always have in mind is that if the research project of the person who first proposed that the world was round rather than flat had been subjected to peer review, it never would have got anywhere. I use that example facetiously, but it has always troubled me that a peer review process kills really unorthodox thinkers. How would you respond to that comment?

Dr. Friesen: It is absolutely true and the history of science is replete with those examples. Many Nobel laureates have begun their lectures with a statement of rejection either by peer review or editorial board.

The Chairman: I raised it because you were laudatory of the process.

Dr. Friesen: It is like democracy. It is imperfect, but it is the best we have.

The Chairman: I will call the next panel of witnesses to the table. We have before the committee Ms Sholzberg-Gray, President and CEO of the Canadian Healthcare Association. Also back with us is Dr. Mary Ellen Jeans, Executive Director of the Canadian Nurses Association. Finally, we have Mr. Charles Pitts, Executive Director of the Coalition for Biomedical and Health Research.

We are celebrating the fact that yesterday the House of Commons passed Bill C-6 with the amendment that this committee proposed and that was developed very much with your help. We very much appreciate that.

Ms Sharon Sholzberg-Gray, President and CEO, Canadian Healthcare Association: Honourable senators, thank you very much for allowing us to appear on Bill C-13. In fact, as you know, there is quite a link between Bill C-6 and Bill C-13. If you had not changed Bill C-6, it is very possible that the work that the CIHR has to do would not be able to be undertaken. Of course, health information is so important in that regard.

In any event, I do not know if I need to repeat what the Canadian Healthcare Association is. I will just briefly say that the CHA is a federation of provincial and territorial hospital and health organizations committed to preserving and strengthening Canada's health system. Through our membership, we represent a broad range of health services and care settings. All of our members benefit from health research, including biomedical research, applied clinical research, health systems research and population health research.

Overall, the CHA is very supportive of the development of the Canadian Institutes of Health Research, as outlined in Bill C-13. This proposed legislation is an important foundation for the needed transformation of health research in Canada. However, while we support the overall thrust of the proposed legislation, CHA has identified several concerns.

These concerns were shared with the House of Commons Standing Committee on Health on December 2, 1999. While some amendments have been made to the bill, those amendments do not address CHA's concerns. Frankly, I am somewhat hesitant to come to a Senate committee bringing amendments again; nonetheless, I think they are important suggestions to make. They are related to the proposed governance and management structure of the CIHR, to the commercialization of health research in Canada, and to the need for transparency and accountability.

First, I will deal with the subject of the proposed governance and management structures. As outlined in the bill, the CIHR president and the chair of the governing council are one and the same person. That flies in the face of many governance and management models that stress transparency and accountability. CHA recommends that the wording of the legislation be changed to state that, either immediately or following the initial five-year term, those two positions shall be filled by different people.

With respect to the term of office for the president, CHA supports the opportunity for the president to be re-appointed after the initial five-year term to allow for continuity and stability, but we suggest that after ten years it would be beneficial to have different leadership. Therefore, CHA recommends that the president be appointed to no more than two consecutive five-year terms.

The appointment criteria for the governing council state that these women and men will reflect a range of relevant backgrounds and disciplines. CHA recommends that these criteria be more specific, that there be some reference to proportional representation of the different fields of health research, which I do not intend to outline here. That will enable the CIHR's decisions and activities to reflect a wide range of needs, issues and perspectives. In addition, CHA recommends the inclusion of consumer or public

representation on the governing council and other decision-making and priority-setting bodies of the CIHR.

On the issue of the commercialization of health research in Canada, CHA recognizes the significant opportunities available domestically and globally for both the public and private sectors to benefit from the commercialization of Canadian health research. However, we feel strongly that a cautionary note is needed in paragraph 4(i) to stress that private-public partnerships in research related to the health of individual Canadians, and the structure and management of our health care system, must ultimately be in the public interest and must not compromise the objectivity of the research, the provision of appropriate treatment and care, or the development of needed public policies. CHA recommends that wording be added to the bill to recognize the spirit of this cautionary note.

On the issue of transparency and accountability, CHA is encouraged to see the requirement of a public annual report by the CIHR and a five-year review of the mandate and performance of each health research institute. To strengthen this transparency and accountability, CHA recommends that Bill C-13 include the provision for a parliamentary review of the CIHR every five years. Given what is at stake in terms of innovation, global competitiveness, the health of Canadians, the effectiveness of the health care system and the amounts of money that will be involved, a regular parliamentary review seems necessary and appropriate.

In conclusion, CHA is cautiously optimistic about the establishment of the CIHR. This note of caution is based on a sense that biomedical and clinical research, as important as they are, will continue to overshadow the other crucial areas of health research in Canada: namely, health systems research and population health research. CHA and our members are looking forward to working with others to implement and support the Canadian Institutes of Health Research. Our association, together with others who are working together in a partnership called the Network for the Advancement of Health Services Research, will be using the evaluation framework developed by that network to ensure that CIHR becomes all that it promises to be.

We have left copies of that framework with the clerk of the committee. We thank you for the opportunity to appear today.

Dr. Mary Ellen Jeans, Executive Director, Canadian Nurses Association: I am pleased to be here to represent the views of the Canadian Nurses Association. We are a federation of provincial regulatory and professional bodies in nursing, representing over 110,000 nurses in Canada. We also have some 30 associate and affiliate members representing a variety of specialties in the field of nursing, including a national group of nurse researchers.

I share with many others our support for the concept of an integrated and multi-disciplinary approach to health research in Canada. As a nurse researcher, I recognize the tremendous value that quality research, broadly disseminated and integrated into practice, can bring to improve the health of Canadians. We all recognize, too, the need in Canada to enhance our research capacity. In the context of a competitive global environment, we must have a well-structured, funded and integrated system for health research that will attract and retain our brightest minds.

The proposed Canadian Institutes of Health Research offers an innovative vision to accomplish an effective national health research infrastructure. We believe that the legislation before you provides the broad enabling framework required to put such a vision in place.

We do have several points we wish to emphasize and a few specific recommendations that we feel will strengthen the legislation. First, we must emphasize that the objective of CIHR, as outlined, must be the improved health of Canadians. The CIHR should exist to meet the needs of Canadians first and foremost, not the needs of researchers first and foremost, although those needs are obviously important, too. This will require the CIHR to build and maintain an appropriate balance between biomedical, clinical, health services, and population health or determinants of health research. There must also be balance between addressing immediate needs for evidence or knowledge and research that continues to examine issues on a long-term basis. As you know, to discover a cure for a disease may take many years, but solving some of the immediate problems in our health care system could be accomplished in a much

shorter time. That balance is needed.

The historical lack of balance in the support and funding of research has created the most concern about this proposal. For example, while nurses make up 75 per cent of health care professionals, nursing research has traditionally received less than 1 per cent of research funding. While the nursing community was very pleased with the creation of the Nursing Research Fund in the 1999 federal budget, that small fund was designed to address very specific research needs, particularly those related to issues such as nursing human resources. We do not see CIHR as being exempt from funding nursing research, particularly clinically based nursing research, because of the existence of the Nursing Research Fund that was created last year. In fact, the nursing research community looks forward to being active participants in a broader, multi-disciplinary, balanced research agenda for Canada.

While the legislation suggests this balanced approach, we believe that a mechanism is required to ensure that that balance is achieved. In establishing a framework for the CIHR, we also recommend that the peer review process used to select health research respect the full range of different research methods and interests.

We would also like to emphasize and encourage the need for broad public participation in the CIHR. The Canadian public and members of stakeholder groups outside of the research community can make valuable contributions to the creation and design of research agendas. The public must be involved in processes and governance of the CIHR, including participation on the proposed advisory boards.

For this legislation to be truly transformational and to ensure that it continues to reflect the expectations of today's legislators as well as the communities involved, the issue of accountability must be addressed. We believe that the criteria for the selection of the proposed institutes, for their evaluation and monitoring, should be articulated. We would encourage the addition of a parliamentary review process to ensure true accountability to Canadians, as my colleague Ms Sholzberg-Gray has already pointed out.

In conclusion, the nurses of Canada welcome this initiative. The legislation before you marks a truly historic turning point in Canadian health research. The Canadian Institutes for Health Research will have a considerable impact on the quality of life of Canadians. The government will soon be appointing the first governing council of this important body. We believe that the leadership, the president, the governing council of CIHR, must reflect this broader and balanced vision of health research. Nursing leaders have a valuable perspective to bring to the CIHR. Nursing research has made an invaluable contribution to the quality of life of Canadians and nursing researchers are well suited to forge ahead a new era of health research for Canada. We welcome the opportunity to be part of this transformation.

[Translation]

Mr. Charles Pitts, Executive Director, the Coalition for Biomedical and Health Research: Mr. Chairman, thank you in my name and in Dr. Barry McLennan's name. He was not able to be here today, but I want to thank you for inviting our Coalition to appear before your committee.

[English]

Our coalition is a non-profit corporation that represents Canada's 16 medical schools, four schools of veterinary medicine, clinical researchers, academic physicians through the Association of Canadian Medical Colleges, the Confederation of Canadian Faculties of Agriculture and Veterinary Medicine, medical specialists, family physicians, the Health Research Foundation of Canada's research-based pharmaceutical companies, and the voluntary sector through the ex officio presence of Canadians for Health Research. On their behalf, thank you for the invitation to be here today. Again, Dr. Barry McLennan sends his regrets.

With the creation of the Canadian Institutes of Health Research, Canada will embark upon an exciting journey. In fact, the creation of CIHR is, in our view, a key element of the federal government's strategy to ensure that Canada comes to and remains at the leading edge of the knowledge-based economy.

In our view, CIHR clearly is supported enthusiastically by a wide coalition of partners in the Canadian

health research community. People want this legislation passed quickly in order for CIHR to begin operations as early as possible. Reflecting the broad appeal of the CIHR concept, The Globe and Mail's public health reporter, André Picard, entitled his March 22 article on the passage of the Medical Research Council of Canada to CIHR, "No tears at the wake for the research council." That article came after discussion with a broad number of researchers in the Canadian community. I can tell you from our contact with both social researchers and biomedical researchers across the country, there is a great deal of enthusiasm and perhaps a new harmony and a new coming together.

I bring only one recommendation that I will give later to this committee. Dr. Barry McLennan was very active as a member of both the task force and the interim governing council in preparation for CIHR. He was able to express to those two groups the views of the biomedical community. As the Coalition for Biomedical and Health Research, we would like to express our sincere thanks to the CIHR interim governing council for having transformed the vision of Canada's new health research community into what we believe will be a very effective structure.

CBHR is convinced that the legislation creating CIHR will lead Canada to the dawn of the most exciting era of health research in our history, a history that has seen a number of important medical discoveries here in Canada and that will, no doubt, open us to a whole new inventory of great breakthroughs. Without a doubt, Canada is about to create a completely new approach to health research that will contribute to international recognition of its leadership in research innovation. This new approach will require significant increases in public investment in health research. It should also encourage greater volunteer, private-sector and public-sector investments from across Canada.

In our view, CIHR will enable researchers to work more effectively in partnership with the private sector. In addition, these partnerships will be organized under CIHR to ensure that the public interest is protected, that the health of Canadians is strengthened and that the health care system is advanced in this country. As an additional benefit, CBHR is convinced that CIHR will provide intellectual pooling and synergies across various research sectors, thus avoiding intellectual and fiscal silo effects, a problem that we commonly see in many institutions in the health area and in education as well.

The proposed institutes will create opportunities for young researchers to come into health research through training, mentorship and networking and will also support existing researchers to sustain their careers. The institutes will help to ensure that Canada reverses the brain drain by retaining the skilled researchers that this country has developed. At least partly as a result of this initiative, we are already seeing encouraging signs that Canadian researchers are returning and that researchers in other countries are seeing Canada as a country of opportunity in innovation.

CIHR will constitute a win-win situation for all Canadians: for the established research community; for research funders, private, public and volunteer; for both human and animal health here and around the world, as our technology and our intellectual properties are shared with the world; for Canadian taxpayers in the short, medium and long terms; and for our young people whose thirst for knowledge and experience will be met with opportunity and new resources.

CBHR's one recommendation then is that this committee promote speedy passage of this bill to your distinguished colleagues of the Senate.

Senator LeBreton: We have had so many meetings with these witnesses. I want to thank you again, Dr. Jeans, Ms Sholzberg-Gray and Mr. Pitts. Your precise, clear representations in the past were a part of our success with Bill C-6.

Regarding the governing council and the issue of proportional representation, I question the make-up of the council. I inquired of earlier witnesses whether they had taken into account provincial agencies or community agencies. Having heard from you, it seems that the area of health research knows no borders. Perhaps the criteria should not be based provincially but, rather, as you suggest, on proportional representation from all the different fields of health research. In your consultations with Health Canada and other groups, have you advanced this recommendation? What has been the response about going more to the experts in the field, rather than worrying about whether we have covered the country geographically?

Ms Jeans: We did present this to the health committee in the House of Commons. We also belong to the Network for the Advancement of Health Services Research. In fact, the interim governing council of CIHR and the CIHR secretariat did solicit input from all stakeholders. By stakeholders, I refer to the broad disciplines involved in health research. They solicited recommendations of names for the governing council. I believe that was an attempt to respect our continuing concern that this balance be achieved. Those names have not been yet announced. It remains to be seen if the council will be balanced. At least we were asked for input.

Ms Sholzberg-Gray: In a letter to Mr. Alan Rock, dated November 4 and sent by the chair of our health research network, which is interested in a broad view of health research including biomedical, clinical, health systems area and population health, we asked that certain principles be observed. We also indicated that we would in the future use the evaluation framework that we were sending. We made, I think, a good case for a governance structure that includes representation from those four broad fields to create the ability to look at things in new ways because people outside the box will be there. We talked about issues of peer review and bringing together in the process people not from just one of those four parts but having all the parts together. We have made the point and it is likely that that is how things will happen in the future.

We recommended that it would be useful to include that direction in the legislation and so make it necessary. Obviously, many other issues must be taken into consideration in naming members of the governing council and advisory committees. We are a country with a large geography, which we cannot ignore. We must ensure that different population groups are part of the process as well. Nonetheless, we should be thinking of these four broad categories at the same time. How we bring all that together will be a challenge, but it can be done.

Senator LeBreton: I support your recommendation that the position should be split after five years, and it is valid to want new blood after ten years.

The bill recommends three-year terms for members of the governing council. Is that a reasonable term for people in the health research area? Sometimes on agencies and boards like this, three years is hardly enough time to work on something as complicated and intricate as health research. As the bill was being drafted, did you have any knowledge about staggering the appointments so that the whole council is not subject to reappointment exactly three years later with a whole new council of appointees coming in? An argument could be made for staggering the appointments, not having them all come due at the same time. In fact, is three years long enough for a term?

Ms Jeans: To my knowledge, although I do not have the reference to the text here, most of the councils do stagger the term. MRC and SSHRC operated in that way, as well.

Is a three-year term long enough? Active researchers are so reluctant to sit on administrative bodies because it takes away from the time they can devote to their intellectual pursuits. At the same time, you want some of those very active researchers on these councils because they live the policies and decisions that are made by the councils. There is a tension around how to get those folks involved without setting too many obstacles that would interfere with their day jobs. It has worked in the past for the MRC council, the SSHRC council, the NSERC council, and so on. I think that CIHR will also have advisory bodies and a different structure that will support continuity. Therefore, I would say that a three-year term is probably adequate.

Some of the questions you are asking are part of the reason we believe that a five-year review is so important. If we do not get it right, let us at least have an opportunity to come back and fix it.

Senator LeBreton: Just for the record, Senator Cook notes that they are staggering the terms. It is in the bill.

Ms Sholzberg-Gray: I was just going to add that the three-year staggering is in the bill. There could be two consecutive terms but we do not know whether people would want two consecutive terms.

You did mention that you supported our proposal to separate the chair of the governing council from the presidency. We were looking at various models like the Canadian Institute for Health Information where the CEO is a different person than the board chair. A number of government bodies have that structure so that the president reports to a chair and a council rather than reporting to a chair who is himself or herself plus the council. That is why we promoted it. We thought it created more accountability and transparency.

We were also concerned about members overstaying, so to speak. We thought ten years was a long time to stay in one position.

Senator LeBreton: She says to a group of senators!

Ms Sholzberg-Gray: I think for a legislator, wisdom and experience are very important. However, it seems to me that if you are a CEO of a particularly innovative research group, ten years is a long time.

Senator Carstairs: Are you suggesting we are not innovative?

Ms Sholzberg-Gray: I better not say any more.

Senator LeBreton: We appreciate the distinctiveness of your group as opposed to ours. Did you have something you wanted to add to that, Mr. Pitts?

Mr. Pitts: Attempts are being made right now to have certain people of the former board of MRC carry over. There would be staggering, and I think that is an important feature to maintain.

Senator Fairbairn: I will preface my questions with an apology because after my questions I will have to run, not because of lack of interest but because I have a sick spouse at home. I wish I could take Dr. Jeans with me to give me a hand.

Both Dr. Jeans and Ms Sholzberg-Gray raised the question of accountability. I do agree with you that, exciting as it is, it is also incredibly important not just to the field of research and to health care, but for individuals. In order that this truly be the success that everyone wishes it to be, I would hope that at the very least we could get a strong public commitment to a parliamentary review. That parliamentary review should involve not just the House of Commons but also the Senate, because we have done this on numerous other occasions. At the very least, I would hope that we could get a strong public commitment on that.

Commercialization came up earlier. In this complex area, this is being raised publicly in the media on a variety of issues. Being in the media, most of the issues would be controversial. I wonder, Ms Sholzberg-Gray, if you could take the opportunity, while you are on the record of this committee hearing, to be more specific in your concerns, even anecdotal if you wish. One should determine how close this new body would want to get into that very difficult area of public interest versus commercialization and perception.

Ms Sholzberg-Gray: First, I want to direct your attention to paragraph 4(i), which talks about the role of CIHR. The only thing it says about commercialization is facilitating the commercialization of health research in Canada. There is neither limitation nor concern as to whether or not it serves the public interest. There is no description as to what that might mean.

I would assume that facilitating the commercialization of health research in Canada would not be a goal in and of itself but that other goals would be attached to it. We know it is important to bring innovations and what not to market and to have all those kinds of transformations. However, when you start to look into the whole issue of at whose cost, you must consider whether it is more important to commercialize or to serve the health needs of Canadians. There should be a defining clause saying something like "provided that at all times the health needs of Canadians will be served first."

Perhaps there should also be some note to the effect that objectivity is really important in research. We have seen a well-publicized case about the commercialization or the commercial support of a research

project and whether that can compromise the conclusions of the project.

Senator Fairbairn: Are you referring to the University of Toronto?

Ms Sholzberg-Gray: Yes, that particular case.

There are other issues, too, as to what is more important. There is the issue of the profit motive in terms of bringing something to market in opposition to the need to serve Canadians. Who benefits? I know the universities are involved in those kinds of agreements on a daily basis. They are very positive most times, both from the point of view of commerce and business and from the point of view of bringing things to the population at large to serve the interests of Canadians. We have to understand that in Canada our health system and health research is being funded through the CIHR with huge government investments. That research ultimately has to be in the public interest and not to serve the particular private interests of any one corporation.

We think it is positive to be involved in commercialization and business, both domestically and overseas for an export market. On the other hand, we must understand that our purpose is to serve the Canadian public.

We do not have particular wording that we want to advise. We just wondered if perhaps someone who excelled in drafting, because we did not seek legal advice on that, could write some descriptive clause, not just "facilitating commercialization." Some further definition should explain that there will be facilitation of commercialization knowing at the outset that, in accordance with the goals of the establishment of the CIHR, the ultimate goal is to improve the health of Canadians. Perhaps there could be a note that the commercial effects are side effects.

Ms Jeans: Again, there needs to be a balance and some criteria. On the one hand, you do not want the tail wagging the dog. In other words, you do not want industry determining the research agenda of a publicly funded Canadian Institutes of Health Research. On the other hand, we must not be ignorant of the economic possibilities. I will give you a real-life example.

In 1975, I was a graduate student of Dr. Ronald Melzak at McGill University. I tested the very first rendition, if you like, of what is now called TENS, transcutaneous electrical nerve stimulation, for the relief of chronic pain. There was no one around then to give me any advice about the potential of that little machine. Today someone is making millions of dollars on that machine, and it is not I and it is not Dr. Melzak and it is not McGill University.

You need a balance. We have invented many things in Canada that we have not taken to the commercial markets for the benefit of the Canadian economy. At the same time, I agree with Ms Sholzberg-Gray that the public interest must be first and that we need criteria to guide the commercialization and the involvement of the for-profit industries in supporting research. Perhaps that kind of wording should be part of the proposed legislation, or there should be direction to the Canadian institutes that they establish principles and criteria that address those values.

Senator Carstairs: I must take exception to this whole debate because you are not reading it properly. You cannot read paragraph 4(i) without reading clause 4. Clause 4 says very clearly:

...its translation into improved health for Canadians...

Everything else follows. I do not understand where the argument is here. It seems to me like terrible nitpicking and I am getting annoyed and frustrated. What is the problem? Clause 4 states:

The objective of the CIHR is to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system...

Ms Sholzberg-Gray: In my answer I did say that the opening paragraph might very well be read to cover that. On the other hand, in paragraph 4(i) "facilitating commercialization" is all by itself. By the way, the

opening paragraph does not necessarily exclude the notion of for-profit. You can improve the health of Canadians also in a for-profit way. The question was ownership and the correct balance. One can read it in, which is what I said in my response.

Senator Carstairs: I think it is not only read in, you cannot read 4(i) without reading what paragraph (i) comes under; so it is there.

The other issue that causes me concern is that it is now becoming very trendy to suggest five-year reviews. Every bill has a five-year review and it will be five-year reviewed in the House of Commons and it will be five-year reviewed in the Senate of Canada. I can anticipate a day when the House of Commons and the Senate do nothing but review because we are building all of these reviews automatically into the legislation.

This body will table a report every single year. If there are problems with those reports, I do not want to wait four years to have them come before me; I want them to come before me right there and then. I am very concerned that, if we build in more of these five-year reviews, everyone will say, "Oh well, wait, it will come up for a five-year review," and I will say, "No, I do not want to wait. I want to review it now." I should like your comments on that.

Ms Jeans: I do not know if I have an answer, but I have a question. By what mechanism could you do that?

Senator Carstairs: They must table an annual report in the House of Commons.

Ms Jeans: MRC has tabled reports for years.

Senator Carstairs: MRC has been called to this committee to explain its annual report. Dr. Friesen and I, who know each other from Manitoba anyway, have really become quite chummy. We keep running into each other at committees while we discuss the operation of the Medical Research Council.

I must say, in principle, that I find this a trendy thing that is really causing me concern about what the future role of parliamentarians will be.

Ms Sholzberg-Gray: From time to time, whether it is built into the legislation or not, the Senate, not the House of Commons, reviews major issues of importance, such as the current review of the medicare system. Perhaps it might be useful at some future date to look at the state of health research in Canada in that broad sense, rather than this constant review.

The Chairman: I find myself on that score completely in agreement with Senator Carstairs. I am also completely in agreement with Senator LeBreton on the first point about separating the chair and the president, although not necessarily for the same reasons. Much work has been done on the governance of all kinds of organizations, be they private-sector corporations or in the voluntary sector or whatever, and just generally good governance principles require that they be separated. I have no problem with your suggestion that rather than amend the bill now and get it stuck back into the mess in the other place, one could easily have a recommendation or observation or whatever you call it that suggests that, following the completion of the first five-year term, that be changed.

I have enormous difficulty with your proportional representation paragraph and the one that talks about consumer and public representation -- and maybe this reflects the many years I had trying to put together national organizations and national bodies of various kinds -- because the more you hamstring by setting in place a bunch of rules, the harder it is to get a really good body. You can put together 15 Canadians who meet all the required tests and you may end up with an extremely ineffective group of people. It seems to me that above all else, when you are looking for excellence, you are looking for excellence that is not required to be constrained by proportional representation from four particular health groups who regard themselves as "in", and then throwing in the odd consumer and throwing in the odd Western Canadian and Atlantic Canadian and so on. I would strongly oppose any constraining of the actual makeup of the council beyond the notion that you want really good people. I would have thought that that was in your interest, too.

Ms Sholzberg-Gray: I know Ms Jeans would like to respond to your point. The new Canadian Institutes for Health Research is a successor, so to speak, to the MRC, and it is quite possible that current members of the MRC might be appointed to the first board. The point we were trying to make is that, because the primary purpose of the MRC was biomedical and clinical research, there has been a great deal of anxiety on the part of many people who fear that in the CIHR health systems research and population health research will not be as valued as biomedical and clinical research. That is why those people have come together in a coalition, and that is why that recommendation was put forward. Whether it needs to be in the legislation or not is another issue. There is a feeling that all parts of the objectives might not be appropriately represented on that governing council.

The Chairman: I understand that concern. However, in my view it would be a disaster to go the other way and legislate a requirement of a particular mathematical formula to make it work. What you are really saying is that you wish to ensure that the council is truly representative and not loaded in favour of one segment or another of the health research population. That I understand. It does seem to me, however, that to try to legislate it rigorously would probably create a much bigger problem.

Ms Jeans, did you wish to comment on that? I really made the statement as an observation, not a question, but I am happy if you wish to comment on it.

Ms Jeans: Historically, a number of groups have been excluded from funding for their research. Our anxiety is to ensure that the broad vision that is described here actually comes about. Some of these recommendations are made out of that anxiety, and it is part of the reason we recommended a five-year review.

The Chairman: Let me pick up on Senator Carstairs' point. The fact is that an annual report will come before Parliament, and at least two of you at the table seem to be get very good at getting access to committees when you need it. I would think that if you were very unhappy with a report, some of us would certainly hear about that and then we would provide you with a forum.

Frankly, that ad hoc mechanism, which allows a much more instantaneous and flexible response, works better. The only reason that in certain cases a five-year review, or a sunset clause in the case of banking legislation, has been put in place is precisely to force the government to deal with issues that it would otherwise rather duck.

In this case, you are proposing a review. I think you are better off with an ad hoc system. If you get bad representation in the first wave, we will hear about it. Since people will have terms expiring in years two and three, that will be a way of dealing with that quickly as opposed to waiting for five years. I urge you to let us know if you are unhappy with the initial allocation and we will attempt to see if we can do anything about it for the second and third year.

I thank the three of you for coming. It is good to see you again.

Senators, our next witnesses are Mr. Upshall, Dr. Reading and Ms DuBick.

Mr. Phil Upshall, Chairman Elect, Canadian Alliance on Mental Illness and Mental Health: Honourable senators, this is indeed an historic first for our movement. I am pleased and honoured to be able to present myself as a consumer-survivor of the mental health process.

The Canadian Alliance on Mental Illness and Mental Health is a new movement on the block that quite adequately meets the chair's indicator as to what a good national group is. We are a consensus group. We do not operate with bylaws or constitutions. We operate only as we unanimously agree.

I am also a member of the Mood Disorders Association of Ontario, where I am the government relations officer and fundraiser. I also had the honour to be on the peer-review mirror committee of the NVHOs, the national voluntary health organizations.

I have filed with the clerk of the committee copies of some of the work that the Canadian Alliance on

Mental Illness and Mental Health has been doing. I should just like to point it out to you briefly so that you know that we have it. The first thing we have is "A Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health." This was just presented to the Federal/Provincial/Territorial Advisory Network on Mental Health in Vancouver on Monday. As a result, some of our members remain there for the best practices conference. This is quite a sophisticated draft of how we go about building a consensus as to how mental health activity should be dealt with in the future.

I have also filed with the clerk a copy of our agreement with the Laboratory Centre for Disease Control dealing with setting up a surveillance system. That is a discussion paper that was released on December 29, 1999. As honourable senators will know, the Laboratory Centre for Disease Control is part of Health Canada. We were quite excited to be working with them on that project.

All honourable senators have a backgrounder on the Canadian Alliance on Mental Illness and Mental Health. I am advised to keep saying Canadian Alliance on Mental Illness and Mental Health so that there is no concern as to relationships. The Canadian Alliance on Mental Illness and Mental Health is made up of the Canadian Mental Health Association, the Canadian Psychiatric Association, the Schizophrenia Society of Canada, the Mood Disorders Association of Canada, and the National Network for Mental Health.

Those last three groups, the Schizophrenia Society of Canada, the Mood Disorders Association of Canada and the National Network for Mental Health, are what we call consumer survivor groups or family groups. They are the dominant groups within the CAMIMH. Therefore, our perspective is that our alliance can totally reflect the needs of those in the communities, those with the mental health problems, mental illness and disorders or their families, who are quite desperate for assistance.

We got together a year and a half ago to try to find a way within ourselves to get our voices heard on the broad national stage. Many of us had worked alone in an effort to get our singular issues placed before the various parties in Ottawa and, quite frankly, we were very unhappy with the results.

Mental illness, as honourable senators will know and as I will point out in a minute, is one of our most significant issues. In the past, it has been the biggest dollar cost in our hospital services, at over 15 per cent. At least 2 million Canadians will be affected directly or as family members by depression, schizophrenia and various other disorders.

We are talking about research today. While 15 per cent of health costs are related to mental illness and mental health, less than 5 per cent of research funds go into it. We have no major national foundation to date.

All of this has brought to our attention that it is necessary to have a national presence on the national stage and to become involved in processes like ours in order hopefully to address the single most important issue, which is the stigma of mental illness and mental health. If we can get CIHR to set up an institute of mental health for research purposes it will do two things. It will get research moving on a national scale, where it is not now, and it will also help us to address the issue of stigma.

Nobody wants to talk about mental illness. Nobody wants to talk about issues that are important to us. Our community is completely sidelined on many occasions when health issues are discussed. We have a wide breadth and depth of expertise at our disposal and we are anxious to make it available to the national health movement.

I believe all honourable senators have our document titled "Canadian Institute of Mental Illness and Mental Health Research: A Working Model." I would ask senators to have a look at the report in some depth, because it provides a great overview in the cover letter and the transmittal letter. Those are the first two items. All the members of our Canadian Alliance on Mental Illness and Mental Health signed the cover letter, as can you see. It sets out in succinct detail why we believe the Canadian Institute of Mental Illness and Mental Health Research is important.

The proposed model supports a wide-based and integrated innovative research approach to mental

disorders. It ranges from the molecule to the brain and all the way to policy and social-cultural issues. The integrated diversity of this institute is demonstrated in its four themes: basic biomedical; applied clinical; health services systems; and social, cultural and health of populations.

I draw your attention as politicians now to other items because of your concern about who is involved in some processes. On page 1 at tab 3 there is evidence of the size and strength of the National Working Group for a Canadian Institute of Mental Illness and Mental Health Research that set about preparing this model at Dr. Friesen's invitation over a year ago. The membership is a microcosm of what our community has to offer to the health research community, and, as you can see, this is one of the few models that has actively involved consumers, survivors, patients and caregivers in the development of the model. We are truly the only democratic model that has been presented -- the one that has involved the grassroots in their entirety as well as some of the brightest psychiatric, neuroscientific and psychiatric-epidemiological researchers and more. It is important for us to tell you about the breadth.

The justification, the burden of illness that Canada has, is set out in the model on pages 3 and 4 at tab 3. The burden of health in Canada, not only in health care costs but also in corrections costs and quality of life factors, is absolutely astonishing. While I cannot quantify it in any reasonable way, I can tell you that it is ten times greater than any particular health care cost you can put your finger on. It is truly beyond measure and something we need to address in great detail.

At tab 5, I would urge you to look at the letters of support that have gone into the interim governing council in support of our modelling effort. We actively sought the involvement of the broader community before we presented our proposal and we are very pleased with the response that we have received to date. To be fair, we have a number of other endorsements, which we will be filing in due course.

Senator LeBreton asked Dr. Friesen about other countries and their institutes. Dr. Friesen responded that the United States has the National Institutes of Health. They also have the National Institute of Mental Health that was set up many years ago for the primary purpose of allowing the consumer survivors and the community involved with mental health the knowledge that government is taking their issues seriously in approaching the stigma. Thank you for the opportunity to be here.

Ms Linda DuBick, Director, Prairie Women's Health Centre of Excellence: Honourable senators, I am pleased to speak to members of the committee on Bill C-13. We welcome and support the concept behind the CIHR as we generally endorse Bill C-13. In particular, we are very supportive of the identification of the four CIHR research quadrants, the transformative intent of the CIHR and the interdisciplinary approaches to be taken by the CIHR. However, we are concerned that the general direction the CIHR seems to be taking and the content of the proposed legislation do not go far enough in confirming the Government of Canada's commitment to women's health research in general and to the kinds of research activities undertaken by the Centres of Excellence for Women's Health Program in particular.

It bears some repeating that both the Liberal Party and the Liberal government have made strong commitments to women's health research and to the Centres of Excellence. For example, the centres fulfilled a Red Book commitment. Most recently, they were cited by the Minister of Health as an important pillar of Health Canada's Women's Health Strategy, which was released earlier this year. We hope that members of this committee will understand and appreciate that the Centres of Excellence, as a concept and as a commitment, pre-date both the Women's Health Strategy and the CIHR. I do not think it is an exaggeration to say that the Centres Of Excellence have stood as a centrepiece of the government's commitment to women's health research and are an important milestone in the evolution of health research in this country.

The centres were created in 1996. There are now five centres and they are located in British Columbia, Ontario, which serves as a national centre, Quebec, the Maritimes and my own centre in the Prairies, which operates in both Manitoba and Saskatchewan. We are committed to women's health research that is women-centred, participatory, action-driven and policy-relevant all around women's health issues.

We bring together community-based and academic researchers and we develop working partnerships

between women's groups, researchers, policy-makers, service providers and individuals. We conduct our research in many ways. One of those ways is by awarding research grants. To give you a flavour of what we are about and what we do, here are a few of the topics that our centre funded recently: the health of Salvadoran women in Manitoba; women survivors of childhood sexual abuse; gender analysis and determinants of health within the Manitoba First Nations model, in partnership with the Assembly of First Nations; the effect of social isolation and loneliness on the health of older women; the effects of caregiving on the health of informal caregivers in rural Saskatchewan; and what women want when it comes to midwifery care.

We also commission research. One of our most recent commissioned works, called "Invisible Women," showed that, despite strong commitments from the governments of Saskatchewan and Manitoba, virtually nothing had been done to ensure that gender had been considered in health needs assessments or health plans conducted by regional health authorities. When we presented the report to the two governments, the centre was asked to work with them to improve the situation.

More timely, perhaps, we are a partner in a national project to examine the impacts of health care privatization on women. Even though Alberta does not fall within the mandate of our centre, we have worked very hard to draw in researchers from Alberta to participate in this project.

We were also asked by Manitoba Health to manage a research project on services to pregnant addicted women. This is an issue that arose from the well-known G case, which received national attention and resulted in a Supreme Court decision. These examples attest to the fact that the centres are meeting the expectations of the program and are doing important work.

I believe that it is important to emphasize that our projects are community-based research. That means that the community affected by the health issue has a say in how the research is planned, conducted and used, and has a say in the peer review.

The Centres Of Excellence program has its own special feature: all of our research is required to have policy relevance, whether it is at the local, regional, provincial or federal level. It is also required that research projects be undertaken by qualified researchers, using accepted research techniques and methodology, including peer review, and policy-makers are also expected to be part of our research teams.

How does all this relate to Bill C-13? The Centres of Excellence were each given \$2 million to use over six years. None of the centres has been given explicit assurance that it will receive continued funding from Health Canada beyond March 31, 2002. We have only 24 months left in our funded mandate and it is now that we are starting to see significant results for those dollars.

What does the CIHR intend to do about women's health research? When we review the main documents available through the Web site, we see only one reference to women's health. We found strong commitments to biomedical and applied clinical research. We did not find a clear and unequivocal commitment to research that links women's health and health systems and services, nor a commitment to research that links women's health and research on social, cultural and population health matters.

We found some broad commitments to various partnerships, especially those with commercial interests. We did not find a prerequisite commitment to the protection of the public interest when undertaking commercialized health research. In women's health, these issues are of vital importance.

We fear there is a medical and academic bias in the CIHR documentation to date. We are left with the distinct impression that once all the legislative and organizational plans are put into place, community research may not stand much of a chance in the scramble to form institutes. If the CIHR becomes the one and only source of federal funding for health research, we fear women's health issues may take a back seat. Equally important, those who support women's health issues will have lost the high profile commitment of the federal government. Women's health will become a part of the CIHR agenda rather than a priority of the Government of Canada.

We do not suggest opposing the CIHR. We acknowledge that it has the potential to make an important

contribution to health research in this country and around the world. What we are concerned about is that the initiative could result in losing the significant gains achieved through the Centres Of Excellence program in terms of the recognition, the high profile and the direct commitment of the federal government to women's health research.

We have pointed out to the interim governing council that, through its international and domestic platforms, Canada with its machinery is obligated to work towards improving women's health. We stated that the CIHR, being part of that government machinery, is also bound by federal policy to integrate gender into science and into its management. It must also integrate women's health issues into its research program. Furthermore, an institute for women's health research was proposed to the CIHR in January of this year by the working group on CIHR gender and women's health research. The establishment of such an institute would be tangible evidence of the government's commitment to women's health research.

I believe the clerk has provided honourable senators with copies of our presentation to the House of Commons Standing Committee on Health. It includes a number of recommendations, and they appear on the last page of the draft. In the interests of time and wishing not to irritate Senator Carstairs again with respect to paragraph 4(i), I will not go over them. However, I should like to ensure that my colleague has a chance to speak.

Dr. Jeff Reading, Health Research Advisor, Assembly of First Nations: Honourable senators, thank you for the opportunity to come to Ottawa in the springtime. I am a Mohawk from Southern Ontario. My mother is from St. John's, Newfoundland. I work at the University of Manitoba. I spend a significant amount of time in Ottawa and I live in Victoria. I think I have the country covered.

The Assembly of First Nations is grateful for the opportunity to speak to you today about research in aboriginal communities. We recognize that the CIHR is a process that is an historic opportunity to re-direct research in this country and to focus on improving the health of Canadians.

It is well documented that First Nations and other aboriginal groups around the country are most at risk for poor health status. There is something in the neighbourhood of an 8- to 15-year gap in life expectancy for aboriginal people. Life expectancy is a very crude measure of total wellness. One can envision that morbidity is much worse in a number of key indicators: diabetes, adolescent suicide and a number of other factors.

Put onto this the demographic age structure where the population is young and growing. Something in the neighbourhood of 50 per cent of our population is under the age of 30. In the total Canadian society, only about a third of the population is under the age of 30. There is a baby boom happening within a targeted population where the health status is particularly poor.

We undertook a research study recently where we interviewed some 10,000 First Nations people in their home communities. We also interviewed Labrador Inuit. We came up with the usual findings that described poor health status, but the study was managed by political organizations across the country. It was the first time that aboriginal groups undertook a national level study and came out with results. It was very invigorating for the people involved. Previous to the study we went across the country and asked people if they would participate in the study. We received a significant amount of resistance to health research when we spoke to people.

People in communities and health care administrators said that they had been studied to death. They feel the research process has exploited them; it has not served our communities the way it should. We were told, "People come here, they measure us, they calculate, they produce reports and then they leave the community and we never know what it was that they did." The question we heard repeatedly was "How will it improve our health?"

Those people said that they would only participate in health research if they had some say over how it would be conducted, who would own the results, how those results would be shared, by whom and for what purpose. We are in this backdraft of negative opinions about research and yet there is an emerging and positive light at the end of the tunnel. We think it is incredibly important that we become involved

in health research agendas at the national level.

As we know, First Nations in particular have a special relationship with the federal Crown that predates Confederation. Health services are delivered to some 600 First Nations across the country at a cost exceeding \$1 billion. Given the demographics and the health status in the communities, those costs will only become worse unless we can get a handle on how to improve the outcomes. In other words, how can we improve health? Research is a natural starting point.

We participated in various calls to have our issues integrated into the CIHR. SSHRC issued a request for proposals on the MRC and I participated with my colleagues as principal investigators to respond to that. We made presentations and wrote reports detailing aboriginal interests in the CIHR. We think that aboriginal issues in the CIHR can highlight to Canadians as a whole the transformative and innovative aspects of what the CIHR is trying to do. If we want to transform the negative impact and reputation of research in native communities, we must extend to the native communities a meaningful role in the research process.

In terms of innovation, there are many areas that we have not been able to look at from a research point of view. We are very good at describing negative consequences of health status on native communities. People regard that as a characterization of native people in general as being in a constant state of chaos. When one characterizes communities that way, it is not too far to extend the discussion to say, "Well, if the people in a community are in a state of chaos, how can they manage their own affairs?" In other words, research, in a subtle way, reinforces unequal power relationships. It does not really reinforce the concept of First Nations governing their own affairs and becoming self-determining.

Those are some of our concerns. We are willing to participate in the CIHR. We have tried to have our issues brought forward and we appreciate the opportunity to speak today.

Finally, I should like to speak about international recognition. Canada has been a leader in indigenous health across the world. We hosted the first international congress on circumpolar health, and that happened in Yellowknife in the 1970s. The next meeting will be held this summer in Norway, north of the Arctic Circle, where we have a large delegation who will be participating.

Researchers in Canada have made an impact on diabetes in indigenous people, and that work has been disseminated across the world in New Zealand, Australia, the United States and South Africa. We have informed the world in terms of indigenous health. I recently came from a meeting in South America and I have other meetings planned in Australia looking at some of the things we have done in primary care.

The issue is not really capacity. We have established a capacity of health researchers and we have made that explicit in our proposal. The issue is one of succession planning. Where is the new generation of health researchers that will focus on aboriginal health? Where will they come from? In the past, the National Health Research Development Program, the Social Sciences and Humanities Research Council, and the Medical Research Council of Canada all allocated significant amounts of resources toward aboriginal health, but it was often fragmented. We see this as an opportunity to consolidate health research dollars in aboriginal health and to build upon our international reputation.

If asked whether they have ever been involved in health research, many of the researchers you will talk to will tell you a story about when they went up to a community or when they did this and that. That was usually in the early part of their careers and it often helps to build their resumés. Then they move on to other things. We are talking about moving beyond that descriptive research and getting into solution-based research. First Nations and aboriginal people have interests across the spectrum, across the four dimensions of health research that are characterized by the CIHR.

The Chairman: I am astonished by your 8- to-15-year life expectancy data. Have there been any comparable studies on how the health status of aboriginal Canadians compares with the health status of aboriginal groups in other developed countries? I am thinking, for example, of the United States, New Zealand, Australia, et cetera. In other words, is this a worldwide problem or is the Canadian situation significantly worse or significantly better than the comparable situation of aboriginal groups in other developed countries? I would exclude South Africa, for example, in order to get a legitimate

comparison.

Mr. Reading: The situation of aboriginal groups in Canada is obviously better than that of indigenous people in Third World countries.

The Chairman: That is why I was trying to take industrialized countries by way of comparison.

Mr. Reading: Certainly the situation has improved in Canada but it is not really fair to characterize the native community in Canada as a homogeneous group. One of the lines of research that we are particularly interested in is what makes some aboriginal communities healthy and others not. That comes from Bob Evans' book of the same title, *Why Are Some People Healthy and Others Not: The Determinants of Health of Populations*.

We know very little about what makes some communities healthier than others, but we need to look at some of the community aspects that make them healthy across the spectrum. There is no doubt that, when you aggregate the results together and come up with very depressing statistics, it does become a self-reinforcing prophesy. People say, "Well, of course I cannot achieve a health status that is comparable to other Canadians," because we are constantly bombarded with the media and the research reports that say that we should have these various problems.

We have led the way. Canada has a good tradition in going into the North and reaching out to remote communities. My own father-in-law was a doctor who came from Africa and worked on the Bay Line in Northern Manitoba. There has been a transformation in those communities up on Hudson's Bay over the 30-year period, with an incredible drop in infant mortality in the North over those 30 years.

We have made some gains but we are now at the nadir of the sort of infectious and communicable diseases. We are starting to see a real increase in chronic diseases. Type 2 diabetes is at epidemic proportions. It is what I call the "modern plague" in native communities. One out of three people living on reserves over age 50 are affected by diabetes. Diabetes causes blindness, renal failure and non-traumatic amputation of limbs. It is also a major risk factor for cardiovascular disease, as I am sure Senator Keon would attest to.

This new wave of chronic conditions that are starting to affect native people really causes much concern, not only for the suffering it will cause but also for the associated economic costs. When you have to fly someone out of a remote community in the middle of a snowstorm to get some sort of acute care at a tertiary care centre to life-saving care, it will be very costly.

When the CIHR is created and starts to develop complex and elegant research questions, we want to sit at the table with the other institute directors and have our issues integrated across their work. It is not appropriate or feasible for First Nations to try to create or recreate everything the CIHR does, but we want to have meaningful integration in all the activities that take place.

Finally, we are starting to move on to the area of molecular and genetic biology, which is a new frontier in medical research. Again, we need to be there with the other people who are involved in that complex area so that we can provide an entry point for their research to our communities and for our processes back to their work. We see it as being a win-win situation and a value-added component to have meaningful integration of aboriginal health.

Senator Carstairs: I wish to be clear in my own mind because I spoke on the bill yesterday in the chamber and I raised aboriginal health issues, in particular the issue of diabetes. Do you see the integration happening not as a separate institute for aboriginal health, but as a component of every single health institute that is established?

Mr. Reading: What we put forward is an aboriginal seat on the governing council and a separate institute for aboriginal health. We really feel that we need to build on our international reputation. Canada can take pride in the fact that we have improved the health status globally of indigenous people. I think, by designating it as an institute within the CIHR, it sends a strong message to other countries that they can come and form linkages with us and we can start to share information in the global sphere. That is a very

important role that we can play internationally.

Senator Carstairs: I have no particular problem with having a separate institute. Do you have a concern that by having a separate institute your issues might be sidelined into that institute so that you would be told by another institute, for example, "Well, you have your own institute so we do not need to study your particular concerns within our institute"?

Mr. Reading: Aboriginal issues completely cross-cut the issues of all the institutes, but there is a type of discipline there and there are certainly issues around culture and geographic setting and different kinds of processes that justify an aboriginal institute. We looked at the proposed structures and the best we could figure out we were not represented on the interim governing council; it is kind of like feeling around in a dark room to figure out what the things inside are.

We assess that, in order to have meaningful participation in the CIHR, we would need to sit at the table with our own research director along with the other directors of the institute. That will be the collegial environment where research will get decided. Those scientific directors will talk.

For example, there is a Canadian aboriginal diabetes strategy, but diabetes cuts across all the areas of biomedical, population health, clinical and health services. All those areas need to have an aboriginal focus. The job will get done. We spend a tremendous amount of money on aboriginal research, but it is really fragmented and does not allow us to get beyond a certain point in terms of our understanding of what makes people healthier. We end up describing the problem very well. We have data coming out of our ears, but we do not have very much information on how to use that to transform the health of First Nations and to meet the needs of other Canadians.

There are all sorts of issues we need to look at. The Government of Canada has invested a lot of money in early childhood education, an intervention that has proved itself in promoting better health outcomes through life. Yet we know very little about how that works and what makes some of these programs better than others. That is just one line of interest.

We cannot replicate all the research dimensions. We need to work in meaningful ways across the country to put forward a research agenda within aboriginal communities.

The final important aspect is that we have had very little success when going to provincial Ministries of Health for research dollars, because research is seen as a federal jurisdiction. We have a special relationship with the federal government and we need to build our research capacities there. The next generation of students, native and non-native, will become involved in research, and in that way we will actually improve life expectancy figures.

Senator Carstairs: Ms DuBick, I do not know whether you were here when Dr. Friesen was speaking earlier this afternoon about the way in which Centres of Excellence would blend with the CIHR. He did not see the CIHR taking over from the Centres of Excellence. That gave me some hope.

This is the same question I asked Dr. Reading: What is the best way to deal with women's health issues? Is it through a separate, stand-alone women's institute, or is it through gender analysis in every institute that is established?

Ms DuBick: Ideally, I think it is both. Let me try to expand on that. The history of women's health research in this country has largely focused on biological and clinical factors. For example, there is a great deal of research on conditions specific to women, like cervical cancer, or conditions that occur most often in women, like breast cancer, and, maybe most of all, on women's reproductive and maternal roles.

One of my friends, who has a charming three-year old daughter, says that when one defines her health in terms of her role as a mother and in terms of her child's health, then one has missed the whole boat. There are also social, economic and cultural factors that impact health. We learned that from population health studies. These are the determinants of health that public health experts have been telling us about for 100 years, frankly.

The research in women's health is not as extensive as conducted by social scientists, where qualitative and quantitative research tend to be pitted against each other. Both have value in women's health and, I would argue, in men's health and in the health of any other defined group as well.

I want to be very careful here because I do not view women as merely another population group. The identification and categorization of people as women or men cuts across all the other population groups. It is the most fundamental defining factor of being human in terms of the social roles and the political, cultural and economic impacts that affect that gender.

There is a case to be made for a separate institute of women's health that can truly be transformative -- to use CIHR language -- in the four quadrants of research that are being proposed. Innovation is required in using all the methodologies at hand. There are the more familiar, traditional sciences and all the research that is being done in a qualitative way to "hear women's voices," as it is often described.

On the other hand, applying gender analysis is important across whatever institutes are finally established. Across the world, gender analysis is becoming an accepted way of doing things. It shows us how policies and programs and research can be applied and conducted to meet human needs based on gender and its meaning in terms of societal roles.

We have heard, and this is just a rumour, that there may be some kind of office attached to the CIHR central administrative function to help other institutes by providing this kind of cross-cutting gender analysis. The committee is probably aware that, in the United States, the Women's Health Research Institute has tried this. One difficulty was that no research money was attached to that office; that did not help in the generation of knowledge or in filling knowledge gaps.

That kind of office must be considered carefully because it can often be perceived as having a policing function in its monitoring of how something like gender analysis is applied. I would like to see, in other words, some kind of cross-cutting application of gender analysis in CIHR, but I also think there is a need for a separate women's health research institute.

Senator Carstairs: Mr. Upshall, I was struck by the statistic that mental illness absorbs 16 per cent of the health care dollar but only generates 5 per cent of the research dollar. Do you know why that is the case?

Mr. Upshall: It is stigma. That statistic refers to public research dollars. As I am sure you are aware, very few private institutions, outside the drug companies, engage in any kind of research, so probably the overall number is even less than that.

Senator Carstairs: It is strictly stigma?

Mr. Upshall: Yes. We have not had a voice at the table before. That is one of the reasons we are asking for a mental illness and mental health institute, so our voices can be heard. It is absolutely incredible. I am sure every one of you knows someone who suffers from a mental illness or whose family has been hit by our epidemic of suicide. It is very difficult to get people to talk about it. If someone who is gainfully employed experiences a depression, the last thing they want to do is talk about it.

Having no one at the table means, unfortunately, that some of the weakest in our community have been ignored. I do not think there are any louder voices prevailing, but I am desperately hoping that the attention brought by CIHR to our community will provide us with our request.

In that regard, the CIHR interim governing council seems to be fixated on a reasonably small number of institutes. Because they are virtual institutes, because the vast majority of decision-making will be undertaken at the interim governing council level, I am at a loss to understand why having a small number of institutes is so important.

Fifteen institutes is not an ungovernable number in my estimation. It would provide a few more institutes for other groups, such as the Canadian Alliance on Mental Illness and Mental Health. It would allow us to have an executive director or an administrator at the table. It certainly would not take away

anything from the peer review function, and would allow us to participate, not only in the top-to-bottom type of discussions within the institute, but in the cross-cutting discussions as well.

Mental health issues are equally as important to the Canadian fabric as cancer and heart and stroke issues, and are entitled to an place of equality. We must be able to shout from the rooftop that it is okay to have a mental illness. It is not a defining characteristic of your being. Those are issues that we must address in our community.

Senator LeBreton: I would like to pursue Senator Carstairs' point about the database on people suffering from mental illness. I suppose it is difficult to obtain the proper data unless you survey doctors on what medications they prescribe for patients. How do you obtain a true database on the scope of the problem? I agree with you, I doubt that there is a person at this table who does not know someone who is being treated in some way for a mental health problem. How do you establish a database?

Mr. Upshall: I am not a researcher, I am a consumer and a survivor. I am just learning about the establishment of a database through the Laboratory Centres for Disease Control activities. I filed a very sophisticated discussion paper with the clerk.

Again, we must get around the issue of stigma. Last fall, I was at a meeting with some StatsCan folks, who were telling me some of the statistics they had. I told them that I did not believe their statistics were accurate. I did not accuse them of not asking the questions, but I did not believe they were asking the right ones.

They gave me the honour of appointing me to the executive committee for the current Canadian Community Health Survey. We had a meeting last week to talk about the questionnaire that has been sent to 120,000 Canadians. They have identified a mental health and mental illness survey for 30,000 Canadians.

We were talking about getting people to respond honestly to questions about mental health. As an example, frequently you will see figures with regard to depression as being primarily female dominated, with males at lower rates. The issue for me has always been that males have been unable, unwilling, and totally inarticulate when it came to discussing their mental health. If the right questions were asked and confidence gained, a totally different set of answers would be forthcoming than those received when asking someone if they have been depressed.

Many of our statistics are literally unbelievable. We do not even have a really good database for suicide because it is so impacted by stigma, that when it happens, frequently families will request that their doctor put it down as natural causes. The real statistical data for suicide is substantially, I will not overemphasize it, but substantially, greater than the numbers you see. As you know, Canada has an unenviable rate of suicide.

Senator LeBreton: In our health care study, we saw companies that dealt with doctors. They followed trend lines based on the types of drugs that were prescribed. I was wondering if there were any way, through that venue, to obtain a better sense of how many people really are affected.

Mr. Upshall: Valium, Prozac, Paxil and other drugs that treat depression are among the highest sellers. The companies that manufacture them are among the most profitable. I can give you that statistic, for sure.

There has been no effort to really correlate that data. The problem is breaking down the inter-provincial or provincial health barriers on privacy of information. Perhaps Dr. Keon would know more than I, but there are some major privacy issues or provincial ownership issues on how the data will be used that I think have not yet been overcome. Hopefully, they will be. It is absolutely essential.

With regard to drugs on the provincial scene, frequently many of our most important drugs are not made available to those who need them the most until those people have gone through the older types of drug therapies. Talk to some of the folks on the streets. In our considered opinion, the streets are the emergency wards for a lot of psychiatric patients.

Senator Robertson: Mr. Upshall, I have a supplementary question to some of the things that you have been saying. Is the lack of research that you identify in Canada paralleled in other developed countries?

Mr. Upshall: Yes. However, in the framework for action paper that we just filed with the federal-provincial-territorial advisory network for mental health, there are summaries of what is happening in Australia and New Zealand. Quite frankly, they are much further ahead than we are. I wish I had my other colleagues here. I believe the United Kingdom is further ahead in its proposals as well. The United States, I think may well be philosophically ahead of us, but practically speaking, there is no indication that they are making health care or research available to those who desperately need it.

Senator Robertson: Dr. Reading, you mentioned earlier that your research on aboriginal peoples was very fragmented, if I understood you correctly. Why is that?

Mr. Reading: I can tell you a little story. I graduated from the University of Toronto in 1994 with a Ph.D. The experience of a relatively new graduate is to come out of a system where there was not a lot of opportunity. In other words, there is a brain drain in research.

I think that people of my graduating class, and after that, have stayed in research because they have a real passion for the work. However, it was not properly funded. Now the CIHR is coming along and injecting cash into it, things are going to get better in terms of connecting research that was generally fragmented.

In aboriginal health it is particularly bad because it was not really fully funded in the first place. There were a couple of university centres with whom we have been working. Notably, there is a centre in McGill that looks at indigenous nutrition. The University of Manitoba, the University of Alberta, UBC, and a couple of other universities, including McMaster and Dalhousie, have centres looking at aboriginal health issues. They operate without a strategic plan, but they work very hard and produce incredible results.

It is open to exploitation. A graduate student can show profound differences in health status between a native and non-native community. That is fine. Get those descriptive results. However, when they finish their thesis, they move on to another field of inquiry.

There is no social capital being built up because there is no institution. There is no structure in place to consolidate aboriginal health information and to go beyond the stage of just describing certain conditions, with some exceptions.

There are some processes that are starting to look at that. Research in other areas, such as women's health, will have an aboriginal component to it, but it will be a discrete box within the business that they do. Why cannot we take those boxes that deal with aboriginal health across a life span in remote and urban communities and start to connect them together in order to really understand what is going on.

Senator Robertson: Do you see the possibility of a coordinating process?

Mr. Reading: Absolutely. That would also send a strong message to the community that the Canadian government is focusing seriously on the concerns of aboriginal people.

Senator Robertson: Will it be difficult to gain back the confidence of aboriginal people who, as you say, have been studied to death?

Mr. Reading: It is remarkable how important the way you do things is in approaching native communities. If people see that their interests are being respected, then they will participate. Things can be done very quickly, and with enthusiasm, because people have not felt a part of the process in the past. It has been very paternalistic.

Now many institutes are being created where native people are starting to manage their own affairs. However, there would still be a vacuum if the process did not include the creation of advanced

knowledge. That seems to be a fundamental prerequisite for native people enjoying more self-determination.

[Translation]

Senator Gill: My questions are for Dr. Reading. On the one hand, do you think the mental health of Natives is deteriorating? On the other, will Bill C-13 help you attain your goals, such as, for example, creating an institute for the Native community, if that were your objective? Finally, do you have the support of the National Assembly concerning these objectives you are pursuing?

[English]

Mr. Reading: Your first question dealt with mental health in native communities. The non-insured health benefits program supplies drugs and other non-insured benefits to First Nations on reserve.

The highest cost-driver of that system is the psychoactive group of medications, the drugs that change your behaviour, your depressive state. I am not a psychologist, I am a community health specialist, but I do know that there are state and trait aspects of mental health. Certain environmental conditions, such as unemployment, lack of a future, poor housing, no economic means to support yourself or your family, will lead someone naturally into depression. Thus, the conditions that result in depression are very high in native communities.

Whether there is an organic base, psychosis, schizophrenia or other, I could not say. However, these kinds of depressive circumstances seem to be totally out of control. We have suicides among children as young as eight years old. I go to many communities across the country where this is a major problem. Those communities are paralyzed.

One problem with researching mental health and depressive states is you must be very sensitive in how you approach the issue. One must ensure that there is a proper system of referrals after a person has identified some issue. For example, if there were sexual abuse, physical violence, or suicide ideation, those things would need to be referred to a proper health professional to ensure that the interview did not cause more problems.

The process of comprehending the amount and nature of disease is an intensive one. This is one of the areas that we have targeted for closer exploration with our colleagues in the CIHR.

Your second question was whether the institute would address these issues in native communities. We are prepared to work with our research colleagues to build capacity within the native community and educate people who are willing to work there to address the entire range of serious health concerns.

Research will not be a panacea. It will not solve the problems of socio-economic status in remote communities and lack of employment, but it will give us a blueprint on how to address the concerns within the native community. Without research, the government will really just be throwing money into a dark hole.

We want to look at what makes some communities healthy and others not. We will then try to share those resources in the network across communities. This is part of a larger movement in terms of the creation of an aboriginal health infrastructure. This process will include looking at health services, how they are delivered, and survey-type research in communities, but deeper questions must also be asked that will require specialists in various highly trained disciplines. It is all about innovation, being on the cutting-edge of what we do not know, and how to find solutions to pressing problems that we do not fully understand.

If we want to demonstrate some good benefits or outcomes of the CIHR in its early days, we can focus on the native community and show some good results of projects that will change things quickly. The opportunity to change is so great within that community.

Senator Gill: Do you get support from the Department of Health?

Mr. Reading: We have worked very closely with them. In fact, one of my colleagues here is from Medical Services Branch of Health Canada. We have worked very closely with the Department of Health and we also have the support of Phil Fontaine, the Grand Chief of the Assembly of First Nations.

Senator Gill: I do not have questions about support from Phil Fontaine, I am just questioning the fact that you want to have an institute. Do you have support for that?

Mr. Reading: I understand they support it and see the usefulness of it. We are hopeful that the interim governing council and the president also see the usefulness of it.

Senator Keon: It has been very interesting listening to all three of you. Your vision of CIHR is that it would be a number of institutes -- mental health, women's health, native people's health. How would this integrate into the core concept of CIHR?

We often blame our health care system, but the big problem in health care has been the disconnection between our health research and the outcomes that we know about, the disconnection between our population health and what we know about that, the disconnection between our public health and what we know about it, and the disconnection of our health care system from the other three.

Thus, we have these four different pods of information that hang out there on their own. The worst example of all is with the indigenous people. The situation is terrible. For example, there are places up north where 30 per cent of the kids are deaf by the time they are 12 years old. This is disgraceful, because all they need is antibiotics. We are not putting the information we have on population health back into the health care delivery system.

I want to know, from each of you, how the CIHR should be designed to overcome these problems.

Ms DuBick: The term "disconnect" has some resonance when considering our Centres of Excellence. In particular, when talking about the quadrants that have to do with population health, health systems and services, I believe that the Centres of Excellence are breaking new ground. They require their research to address issues in population health, and health systems and services, to ensure that the research is designed to provide policy recommendations. Thus, we can ensure that decision makers will have the information they require to create policies, programs and services that can do a better job, in our case, for women's health.

Over the years of our mandate, we have developed an infrastructure of researchers, policymakers, health advocates, community groups and service providers who work in women's health and who have worked hard to "connect" that "disconnect" again. They have tried to bridge the languages of academic research and community organizations, because they are different tongues really, and find a way to balance the interests of researchers, community groups and policymakers and end up with product that benefits them all. I am not saying that we are perfect, but I believe our experience should not be lost and that we can offer, perhaps, some wisdom to the CIHR in terms of attempting that balancing act among interests and trying to be transformative and innovative.

Mr. Upshall: I would agree with much of what Ms DuBick had to say. The mental illness and mental health community constitutes a huge portion of the population. That fact alone dictates that we be at the table. The proposed Canadian Institutes of Health Research legislation is set up to deal with your concerns in the sense that the vast majority of decision making will be at the governing council. Eighty per cent of the research grants will be provided through the non-institute granting peer review processes and the researcher will have the opportunity to choose the institute with which to affiliate.

It is a question of trust, in that we want the opportunity to be at the table so that we can understand and trust the process. Involvement in the process, for our community, has been negligible. Therefore, we do not trust past processes. This is a new process and we would like to feel that we can trust it. The best way to do that is to be at the table. We have a research community that is highly recognized and willing to involve, as some other research communities are not, people such as the consumer/survivors and those who can make a difference in determining research patterns.

I do not believe that 15 or 20 institutes would be unmanageable within the structure of 80 to 20. The more institutes there are, within reason, then the more opportunity the executive director, or the institute advisory board, would have to deal with such things as challenge grants and develop consideration of issues that would include native mental health, native health, women's health, or in our case, mental illness and mental health considerations.

The other aspect, and particularly in respect of mental illness and mental health issues, is that we are not only in a silo of our own, but we are also quite involved in many cross-cutting activities. We anticipate that collegiality would be demanded and our researchers would be anxious to work with the researchers of other communities. I believe that the opportunity exists to meet with them and develop cross-cutting and, perhaps, joint challenge programs. These collaborative efforts between one or two institutes have a greater opportunity to exist than if we have a massive governing council with four or five virtual institutes trying to manage the whole of health care research in Canada. I hope that helps.

Mr. Reading: It is a very interesting question that is a bit tricky to answer. Actually, it is a question of healthy public policy.

I have worked in hospitals, in political organizations, in health centres in the north, and I have worked as a university-based researcher in all kind of communities. Thus, I have seen the dilemma -- the stacks of little empires that do not talk to each other. I believe that the CIHR model, as put forward, is trying to create national networks where researchers collaborate in networks of perhaps 500 trained researchers to attack various issues around health. When that kind of meeting of the minds takes place, the result is incredibly innovative solutions to very complex problems that you would not achieve with only one Nobel Prize laureate sitting in a lab or office somewhere. The whole process of CIHR is an example of collaboration across the sectors.

Once the model proves itself -- innovative and transformative -- it will connect ministries at the level of governance and the result will be healthy public policies. Canadian core values are equity and fairness. If it were simply a question of money, goodwill, or health statistics that would improve the well-being of native people, then it would have already happened. It is a question of connecting people in national networks and creating healthy public policies that make communities better places to live -- easy to say but very hard to do. It is a question of the responsiveness of Indian Affairs to some of the housing conditions on reserves and understanding that it is in everyone's interest to improve those determinants of health. There will be some downstream savings in terms of costs, and the same will apply to areas such as nutrition and providing exercise programs for children -- keep them busy with healthy activities so that they are less tempted to get involved in minor crime. There is a great deal of boredom in some communities. Therefore, it is wise to provide a determinants of health model, then take the results and feed them to various public policy forums to produce changes.

Most of the communities in Canada have 90 per cent unemployment. I do not care how many doctors or nurses are placed in the community, health status will not improve under those conditions. How much evidence do we have to pile on to convince policymakers to improve those conditions? I am not trying to paint a doomsday scenario, and there are many strategic investments being made, such as early childhood education, but we must build on those kinds of success factors. If we cannot participate as equal and meaningful players in this collegial environment of these national institutes, then we must go, cap in hand, and ask researchers, scientific directors and members of the governing council, "How will you address our concerns around everything from tuberculosis to diabetes and all the other health concerns?"

Finally, the United Nations, for seven years in a row, has said that Canada is the best place to live on the planet. If that had happened once or twice, we could say that it was a fluke, but not when it has happened seven years in a row.

Now, we have this population that is not difficult to find; we know exactly where they live, and we can intervene and can send a strong message that we care about their health concerns. However, if that does not happen, we may regress a little and we feel that we are not really being adequately represented, and that our concerns are not really respected.

The Chairman: Honourable senators, I will now invite our last group of witnesses to the table. They are Dr. Henry Dinsdale and Dr. Richard Carpentier of the National Council on Ethics in Human Research.

Dr. Henry Dinsdale, Immediate Past-President, National Council on Ethics in Human Research: Honourable senators, I will try to pick out a few of the highlights from the material that has been circulated.

I am a medical neurologist, professor emeritus at Queen's University, and immediate past-president of the National Council on Ethics in Human Research. I have also served as a member of council and as vice-president of the MRC and president of the Royal College of Physicians and Surgeons of Canada, which are all groups obviously very interested in this legislation.

Dr. Richard Carpentier, Executive Director of the National Council on Ethics in Human Research, obtained his doctorate in philosophy and, in addition to administrative duties, has extensive hands-on experience through his membership on research ethics boards.

NCEHR is very supportive of Bill C-13. This vision will encompass a wide range of research disciplines that, collectively, will contribute to a better understanding of the determinants of health and the cause and cure of illness among Canadians.

Health research is exciting and full of opportunities. Dramatic advances in prevention and treatment of disease have come from research programs at universities, hospitals, and in the private sector. At the same time, we have seen public confidence in science and scientific advice to government rocked in the United Kingdom by such developments as mad cow disease and its apparent transmission to humans. There is public uncertainty about applications of biotechnology and gene therapy. Infrequent examples of scientific misconduct in laboratories and clinical trials are made highly visible owing to a new probing environment by the national media.

Public interest in science is increasing, but public trust in science requires transparent and credible procedures in many areas, and none more important than the protection of the human subjects of research. Federal policy must preserve the benefits of research while at the same time protecting against possible abuse or unnecessary harm to research subjects. NCEHR notes with interest that amendments to the bill include strengthening the application of ethical principles. The research councils have set high standards in their tri-council policy statement, but effective oversight is required to ensure compliance with those standards.

I have just a brief word about the National Council on Ethics in Human Research. The mission is simple: to advance the protection and promotion of the well-being of human participants in research and to foster high ethical standards for the conduct of research involving humans.

The national council was in fact founded in the early 1980s, when Dr. Pierre Bois, then president of the Medical Research Council, felt that it was advisable to have an arm's length autonomous organization to assist research ethics boards in their work. At the request of the Medical Research Council, and with additional funding support from Health Canada, the Royal College of Physicians and Surgeons agreed to take on this job. The NCEHR has been located in the Royal College since that time, which has given support in kind.

NSERC and SSHRC joined the funding group supporting NCEHR in 1995, and the National Council on Bioethics in Human Research changed its name to the National Council on Ethics in Human Research to reflect its broadened mandate.

NCEHR's council now includes representatives from aboriginal and non-aboriginal communities, and a variety of disciplines, including ethics, law, sociology, nursing, medicine, philosophy, sociology and journalism. It is important for you to realize the central importance of research ethics boards. The Nuremberg Code, the Declaration of Helsinki, and the tri-council policy statement all require that the design and performance of experimental procedures be approved by an ethics committee independent of the investigator and sponsors.

The first duty of the ethics board is to protect the interests of human participants in research. These are small committees made up from a variety of disciplines, as noted in these notes, and usually such a committee is an under-resourced and under-supported process in the institution.

I will not review in detail the various terms of reference of NCEHR. Suffice it to say that those listed show the ways in which NCEHR attempts to assist and support research ethics boards and their works throughout the country. We achieve this through regional workshops, site visits, publications, and a heavily used list serve.

CIHR will encompass a broad and exciting range of health research, but CIHR will not support most of the health research in Canada. Industry, voluntary agencies, sources from other countries, and even unfunded research will comprise the majority of biomedical research in Canada. NCEHR's mandate is the protection of all human subjects involved in research, irrespective of the sponsorship of that research.

Most REBs in Canada are affiliated with institutions, such as universities and hospitals. However, the recent expansion of industry sponsored clinical trials has been accompanied by the rapid growth of independent, for-profit, contract research organizations. They provide drug development services to the pharmaceutical, generic drug, and biotechnology industries. CROs make increasing use of privately organized for-profit REBs, designed for rapid review of protocols. There is no mechanism in Canada at the present time to determine the scope and impact of for-profit REBs.

In the United States, the Office for the Protection From Research Risks has the force of legislation to investigate REBs and their process of ethics review, whether in universities, teaching hospitals, or the private sector. Vigilance by OPRR has in fact resulted in the suspension of research in a number of prestigious American universities during the past year because of deficiencies in their ethics review procedures.

NCEHR has a voluntary site-visit program that provides advice to REBs about their ethical review of research. However, in Canada at the present time there is no process of certification, accreditation or regular inspection of the research ethics review procedures at universities, hospitals, or in the private sector. NCEHR believes that a regular process of assessment must be developed. In order for such a process to have the public's confidence, it must be transparent and at arm's length with the sponsors of research. NCEHR is examining models of such review procedures. Given appropriate resources, it is prepared to implement the most appropriate model.

MRC created a standing committee on ethics a number of years ago. That committee and its staff have promoted debate about ethics in MRC and have created initiatives such as the tri-council policy statement. Proposals have been forwarded from that committee for continuation of its activities in CIHR. Other groups have submitted opinions about the shape and activities of ethics in CIHR. Whatever that final form may be, it is essential for CIHR and NCEHR to have effective communication so that their distinctive and complementary roles can serve the interests of the subjects of human research.

In conclusion, NCEHR strongly supports Bill C-13. However, it must be accompanied by increased resources for the heavily burdened ethics review process, linked to but independent from the funders of research. The time is overdue for the creation of an effective, efficient, and independent oversight mechanism of the process of ethics review, not only for projects funded by CIHR but for that majority of research with other sponsors.

NCEHR looks forward to working with CIHR and Health Canada on these important issues, of which the ultimate aim is the protection of research subjects.

The Chairman: Thank you, Dr. Dinsdale. You were not here earlier today when we had an interesting exchange with Dr. Bartha Marie Knoppers of the University of Montreal. As a result of that, we came to the conclusion that we need to have a much longer discussion outside the context of this bill on the ethics question.

I ask this question, not to provoke a debate, but as a genuine question, to try to understand: Does the

medical fraternity distinguish between ethical decisions and moral decisions? I do not want to enter into the abortion debate, but it provides an interesting example. There are a great many people who would take the view that their position on abortion is a moral judgment. Do your ethics boards consider abortion to be an ethical issue or something else? Is that an issue with which those boards would be concerned? To that extent, are morals and ethics different, or are they the same?

How do you differentiate between subjective values, which are moral issues, and ethics, which, I presume from the way you describe it, has, in theory at least, an element of objectivity?

Mr. Dinsdale: The role of the research ethics boards to which I referred is to focus on the first word, "research". These ethics boards simply review the ethical credibility of a research project. An institution, a hospital, for instance, will undoubtedly have another ethics committee of the board that will deal with the more broadly based moral issues.

The Chairman: Therefore, something could be ethical but immoral?

Mr. Dinsdale: I am on shaky ground, Mr. Chairman.

The Chairman: I am not trying to provoke an argument. I am simply trying to understand whether something that is ethical to you might not be ethical to me. In other words, to what extent are ethics an objective measure, which is the way one thinks of research, versus the collective subjective judgment of the people on the board? That is what I am trying to understand.

Mr. Dinsdale: I would like to come back to the distinction between the two kinds of ethical discussion, because that is important. For instance, if one were in a religious hospital and the ethical advice of the board of highest discussion in that institution considered abortion to be immoral, such procedures would not take place in that institution.

If we moved over to a secular institution where abortion was an accepted process within their health services, an individual in the department of obstetrics might say, "I would like to do a research study on the psychological effects on young unmarried women having abortions." The research ethics committee would then review that application. It would look at the scientific question to determine whether it was a good question and whether it could be answered with the proposed study. In other words, they would pass a scientific judgment. Then there would be a number of issues about the protection of the subjects who would be enrolled, their confidentiality, and so forth.

In a way, there are two different levels and, therefore, the research ethics boards ordinarily do not get involved in those broader moral questions.

The Chairman: So to that extent there is presumably some more objective measure of whether something is ethical?

Mr. Dinsdale: Yes, and the fundamental ethical principles that underline good research are very well understood by the conscientious community. For instance, they arise from obvious sources.

The Chairman: Even by people of different moral persuasions?

Mr. Dinsdale: Exactly. Just arising out of the Nuremberg Trials, one of first principles of any involvement of a human in research is voluntary consent.

Senator Carstairs: Thank you, Dr. Dinsdale, for raising an issue that no one else has raised, that being that the work of any research community is only as good as the peer review, and also the ethical review that goes along with that peer review. I take heart from your comment that with anything this new institute does it will have to also put money aside for the kind of ethical review you recommend in your paper.

I will go a little further than that. We have had some incidents this year in which researchers have seriously questioned what their own ethical problems were with a contract with a particular

pharmaceutical company. Is there a need to go further? Is there a need sometimes for legislation to ease the ethical dilemma that researchers might find themselves in? They may have a contract with a particular company, but they also have a contract with the human race. It seems to me that a contract with the human race takes precedence over their contract with the research company. Do we need to go further?

Mr. Dinsdale: There are two or three very critical elements in that question. First, with regard to whether there is need for legislation, I find the scene in Canada extraordinarily complex in trying to get an oversight mechanism on the research ethics process review.

For instance, I referred to some problems at American universities. The usual problems were inadequate staffing of the research ethics board; too much work to do; doing too much too quickly and not thoroughly enough; not keeping notes, which is a very bureaucratic penalty to lay on them; and very little monitoring. These are key problems.

Justice Krever says that the monitoring of any regulation group will only be as good, by and large, as the amount of resources given to it, and they will never be enough to do what people would want in a perfect world.

There is an example in Alberta. It is a unique and very interesting model. They are trying to get a handle on the research being done in the offices of physicians who are not affiliated with an institution. If a drug company says it would like to do a particular study and asks the physician to gather a certain number of patients, the physician may join up. Where is the research ethics board? Is there an independent research ethics board that reviews the quality of that investigation, and how can we get a handle on it?

The Alberta College of Physicians and Surgeons offered to set up its own committee. Every physician licensed in Alberta who participates in a clinical trial who is not at one of the universities or in an institution that has an REB must have that research vetted by our research ethics board. Alberta is the only province right now that has an oversight mechanism to at least get an inventory of what is going on in the province.

Do we need legislation? Presumably, the college has been legislated and, under its powers, it can do certain things, so one might say we do not need special legislation there. How do we get at the independent research ethics boards?

The Royal College and the accreditation system of hospitals, by dint of moral suasion, ends up having people agreeing. The universities agree to have the Royal College come and evaluate their program and offer approval. The hospitals agree to let the review group come in and offer an accreditation. We like to think in Canada that those voluntary mechanisms can still be effective and efficient. Our American neighbours tend to go for harder-edged legislation, which some feel can lead to a kind of rush to the bottom in terms of the standards required in legislation.

We have talked about this a good deal and there seems to be a hope that credible mechanisms can be put in place and there will be no need for legislation. If that is naive in terms of the enormous financial issues and the other elements at work in this business as it evolves, I just do not know yet.

Senator Carstairs: My final question deals with children. Rightfully, we are doing a great deal of research on children. There is a famous Manitoba case of a boy who was accidentally castrated through physician error and was raised as a girl, while his twin brother was raised as a boy. In watching that, it seemed that the boys wanted out of the research project long before the parents were willing to let them out of it. When do children get the right to make decisions about their voluntary consent?

Mr. Dinsdale: That is an area that has been debated strongly. The National Council on Bioethics held a number of workshops and came up with position papers that modified some of the MRC rules in this area.

You will get differing opinions on this. There is the legal age of consent, yet studies clearly show that children aged 12 or 13 can make very good judgments in many areas. A research ethics board, reviewing

this in the context of research, would take each case on its own merits in terms of the aspects involved. Just last week, we were talking about a case in Minneapolis, where a researcher wanted to give high school children, aged 12 to 14, a questionnaire relating to sexual practices and their knowledge of AIDS and how one influences the other. The investigator was going to send a closed letter to the parents asking them for passive consent: "Would you agree to have your child fill in a questionnaire?"

It is incredible the questions that arise out of a project like that. For instance, how many parents had English as a first language and could even read the letter that came to them? How were the questions phrased that the child was going to answer? If he or she ticked off a bunch of noes, would it look as though other kids in the classroom must be behaving differently? It went on and on.

By and large, the feeling was that a 13-year-old could fill out such a questionnaire; but, in looking at it closer, there are many problems. What is the school board's position?

Each case should be decided on its own merit. I am certainly not an expert in that area in terms of the case law, as it were.

The Chairman: In reply to Senator Carstairs, you said you would prefer not to have legislation, but would hope to get a set of practices that are essentially voluntary. There are rumours that legislation might be forthcoming from the work of the Royal Commission on Reproductive Technology. Is it a fair comment that, if you could avoid legislation in that specific case, that would be the preferable way to go?

Mr. Dinsdale: I was certainly not on that royal commission, but I think the issues there are somewhat different. That is an example of how public and professional attitudes can change with time. If you look at the minutes of the discussion and at the recommendations coming from the royal commission, and some things that were thought must go into the Criminal Code, it is obvious that people have changed their opinions about that. The public moves on.

Perhaps legislation is required, for instance, to ensure that a professional who wants to head a reproductive clinic must be licensed -- and through what licensing mechanism I do not know, but things change so rapidly that any legislation must be very enabling.

Senator Keon: When CIHR is up and running, do you see the Royal College being capable of continuing to house and foster the National Centre on Ethics in Human Research?

Mr. Dinsdale: The Royal College has provided support in kind, providing space and so forth. There is still a willingness to continue to do that. Speaking from the viewpoint of a clinical investigator, there is an intermediate area between the Royal College, NCEHR and CIHR that has not quite been grasped. Personally, I am hoping to see the Royal College take more initiative in this area. It deals with the responsibilities of clinical investigators with regard to clinical trials and other things.

We have a responsibility, obviously, to ensure that the very best question is being asked and that the patients who agree to be subjects are being involved in the very best kinds of projects, because there is always a finite number of appropriate patients for various clinical trials. In my opinion, neither the MRC nor the Royal College, nor any other professional group at this point -- even though MRC has done such things as create the gold standard for the MRC scholar and so forth -- no one has given the suggestion that the neurologists or the cardiologists should get organized in a particular way, with their scientific subcommittees, and tell industry: "Look. You show us your five best drugs coming down the pipe, and our scientific committee will decide which drug we think is most meritorious of evaluation." Since we would have all the key centres across the country agreeing to work within this consortium, we would begin to get some credibility. No one has yet done that.

I simply mention that because there are some ethical aspects there and some training aspects that would involve the Royal College, and, coming back to standards created by the funding councils, there is a kind of network.

In any case, I believe the Royal College is prepared to continue to provide a home for NCEHR at this

point in this time.

The Chairman: Thank you very much, Dr. Dinsdale.

We are adjourned until 11 a.m. tomorrow morning.

The committee adjourned.





Second Session
Thirty-sixth Parliament, 1999-2000

SENATE OF CANADA

*Proceedings of the Standing
Senate Committee on*

Social Affairs, Science and Technology

Chairman:
The Honourable MICHAEL KIRBY

Thursday, April 6, 2000

Issue No. 12

Second and last meeting on:
Bill C-13, An Act to establish
the Canadian Institutes of Health Research,
to repeal the Medical Research Council Act and
to make consequential amendments to other Acts
and

Fifth meeting on:
The state of the health care system in Canada

INCLUDING:
THE SIXTH REPORT OF THE COMMITTEE
(Bill C-13)

WITNESSES:
(See back cover)

Deuxième session de la
trente-sixième législature, 1999-2000

SÉNAT DU CANADA

*Délibérations du comité
sénatorial permanent des*

Affaires sociales, des sciences et de la technologie

Président:
L'honorable MICHAEL KIRBY

Le jeudi 6 avril 2000

Fascicule n° 12

Deuxième et dernière réunion concernant:
Le projet de loi C-13, Loi portant la création
des Instituts de recherche en santé du Canada,
abrogeant la Loi sur le Conseil de recherches médica-
les et modifiant d'autres lois en conséquence
et

Cinquième réunion concernant:
L'état du système de santé au Canada

Y COMPRIS:
LE SIXIÈME RAPPORT DU COMITÉ
(projet de loi C-13)

TÉMOINS:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chairman*

and

The Honourable Senators:

Beaudoin	Keon
* Boudreau, P.C.	* Lynch-Staunton
(or Hays)	(or Kinsella)
Callbeck	Mahovlich
Carstairs	Robertson
Cohen	Robichaud, P.C.
Cook	(<i>Saint-Louis-de-Kent</i>)
Fairbairn, P.C.	

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee:

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Mahovlich substituted for that of the Honourable Senator Gill (*April 6, 2000*).

The name of the Honourable Senator Robichaud, P.C., substituted for that of the Honourable Senator Losier-Cool (*April 6, 2000*).

The name of the Honourable Senator Losier-Cool substituted for that of the Honourable Senator Pépin (*April 6, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjory LeBreton

et

Les honorables sénateurs:

Beaudoin	Keon
* Boudreau, c.p.	* Lynch-Staunton
(ou Hays)	(ou Kinsella)
Callbeck	Mahovlich
Carstairs	Robertson
Cohen	Robichaud, c.p.
Cook	(<i>Saint-Louis-de-Kent</i>)
Fairbairn, c.p.	

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Mahovlich substitué à celui de l'honorable sénateur Gill (*le 6 avril 2000*).

Le nom de l'honorable sénateur Robichaud, c.p., substitué à celui de l'honorable sénateur Losier-Cool (*le 6 avril 2000*).

Le nom de l'honorable sénateur Losier-Cool substitué à celui de l'honorable sénateur Pépin (*le 6 avril 2000*).

MINUTES OF PROCEEDINGS

OTTAWA, Thursday, April 6, 2000

(17)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 11:08 a.m., the Chairman, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Callbeck, Carstairs, Cohen, Cook, Fairbairn, P.C., Gill, Kirby, LeBreton, Losier-Cool, Mahovlich (11:26 a.m.), Robertson and Robichaud, P.C. (*Saint-Louis-de-Kent*) (11:26 a.m.) (12).

Other senator present: The Honourable Senator Roche (1).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore

Also in attendance: The official reporters of the Senate.

Pursuant to the Order of Reference adopted by the Senate on Tuesday, April 4, 2000, the committee continued its consideration of Bill C-13, An Act to establish the Canadian Institutes of Health Research, to repeal the Medical Research Council Act and to make consequential amendments to other Acts. (*For complete text of Order of Reference see proceedings of the committee, Issue No. 11.*)

WITNESSES:

From the National Voluntary Organizations Working in Health:

Penelope Marrett.

From the Council for Health Research in Canada:

Mr. David Hill, President;

Dr. Ronald Worton, Director of Research.

Mr. Hill made a statement. Dr. Worton made a statement. Ms Marrett made a statement. The witnesses answered questions.

The Chair made a statement.

It was agreed — That the Chair write to Dr. Henry Friesen, Chair of the Interim Governing Council of the Canadian Institutes of Health Research regarding letters received from the Congress of Aboriginal Peoples and from the Canadian Medical Association about C-13.

It was moved by Senator Carstairs — That Bill C-13 be reported to the Senate without amendments and that the observations of the committee be attached as an appendix.

The question being put on the motion, it was adopted.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see proceedings of the committee, Issue No. 8.*)

WITNESSES:

From the University of British Columbia:

PROCÈS-VERBAL

OTTAWA, le jeudi 6 avril 2000

(17)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 11 h 08, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Callbeck, Carstairs, Cohen, Cook, Fairbairn, c.p., Gill, Kirby, LeBreton, Losier-Cool, Mahovlich (11 h 26), Robertson et Robichaud, c.p. (*Saint-Louis-de-Kent*) (11 h 26) (12).

Autre sénateur présent: L'honorable sénateur Roche (1).

Également présente: Du Service de recherche de la Bibliothèque du Parlement: Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

Conformément à l'ordre de renvoi adopté par le Sénat le mardi 4 avril 2000, le comité poursuit son étude du projet de loi C-13, Loi portant la création des Instituts de recherche en santé du Canada, abrogeant la Loi sur le Conseil de recherches médicales et modifiant d'autres lois en conséquence. (*Le texte complet de l'ordre de renvoi figure dans le fascicule n° 11 des délibérations du comité.*)

TÉMOINS:

Des Associations nationales bénévoles oeuvrant dans le domaine de la santé:

Penelope Marrett.

Du Conseil pour la recherche en santé au Canada:

M. David Hill, président;

Dr Ronald Worton, directeur de la recherche.

M. Hill fait une déclaration. Le docteur Worton fait une déclaration. Mme Marrett fait une déclaration. Les témoins répondent aux questions.

Le président fait une déclaration.

Il est convenu — Que le président écrive à M. Henry Friesen, président du conseil intérimaire d'administration des Instituts de recherche en santé du Canada à propos de lettres envoyées par le Congrès des peuples autochtones et par l'Association médicale canadienne au sujet du projet de loi C-13.

Il est proposé par le sénateur Carstairs — De renvoyer le projet de loi C-13 au Sénat sans amendement et de joindre les observations du comité en annexe.

La question, mise aux voix, est adoptée.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale sur l'état du système de santé au Canada. (*Le texte complet de l'ordre de renvoi figure dans le fascicule n° 8 des délibérations du comité.*)

TÉMOINS:

De l'Université de la Colombie-Britannique:

Robert G. Evans, Director, Population Health Program.

From the Canadian Centre for Policy Alternatives:

Colleen Fuller, Research Associate.

From the Fraser Institute:

Martin Zelder, Director of Health Policy Research.

The Chair made a statement.

Mr. Zelder made a statement. Ms Fuller made a statement. Professor Evans made a statement. The witnesses answered questions.

At 1:10 p.m., Senator Carstairs took the Chair.

At 1:12 p.m., Senator Kirby resumed the Chair.

At 1:48 p.m., the committee adjourned to the call of the Chair.

ATTEST:

Robert G. Evans, directeur, Programme de santé des populations.

Du Centre canadien de politiques alternatives:

Colleen Fuller, chercheuse associée.

De l'Institut Fraser:

Martin Zelder, directeur de la recherche sur les politiques de santé.

Le président fait une déclaration.

M. Zelder fait une déclaration. Mme Fuller fait une déclaration. M. Evans fait une déclaration. Les témoins répondent aux questions.

À 13 h 10, le sénateur Carstairs occupe le fauteuil.

À 13 h 12, le sénateur Kirby reprend le fauteuil.

À 13 h 48, la séance est levée jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

REPORT OF THE COMMITTEE

THURSDAY, April 6, 2000

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to present its

SIXTH REPORT

Your Committee, to which was referred Bill C-13, An Act to establish the Canadian Institutes of Health Research, to repeal the Medical Research Council Act and to make consequential amendments to other Acts, in obedience to the Order of Reference of Tuesday, April 4, 2000, has examined the said Bill and now reports the same without amendment.

Attached as an appendix to this Report are the observations of your committee on Bill C-13.

Respectfully submitted,

RAPPORT DU COMITÉ

Le JEUDI 6 avril 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de présenter son

SIXIÈME RAPPORT

Votre comité, auquel a été déféré le projet de loi C-13, Loi portant création des Instituts de recherche en santé du Canada, abrogeant la Loi sur le Conseil de recherches médicales et modifiant d'autres lois en conséquence, conformément à l'ordre de renvoi du mardi 4 avril 2000, a étudié ledit projet de loi et en fait maintenant rapport sans modifications.

Ont été jointes en annexe au présent rapport les observations de votre comité sur le projet de loi C-13.

Respectueusement soumis,

Le président

MICHAEL KIRBY

Chairman

APPENDIX

Bill C-13, An Act to establish the Canadian Institutes of Health Research, to repeal the Medical Research Council Act and to make consequential amendments to other Acts

Observations of the Standing Senate Committee on Social Affairs, Science and Technology

During the hearings of the Standing Senate Committee on Social Affairs, Science and Technology on Bill C-13, An Act to establish the Canadian Institutes of Health Research, to repeal the Medical Research Council Act and to make consequential amendments to other Acts, no witnesses spoke against the legislation. The Committee was told that the Canadian Institutes of Health Research (the CIHR) would eliminate longstanding barriers of discipline and geography through innovative "virtual" linkages and networks. We also heard that these virtual institutes would be multi-disciplinary in nature and would foster the integration of the four sectors of health research — basic biomedical research, applied clinical research, research on health care systems and services and, population health research. The Committee strongly supports this innovative approach.

Although witnesses were very supportive of the development of the CIHR, some suggestions were made with respect to the selection of the research institutes. While Bill C-13 provides for the creation of a number of institutes, it does not specify how many of them will be created, nor does it identify any fields of research. These decisions will be the responsibility of the Governing Council of the CIHR. A number of witnesses stressed that particular attention should be given to Aboriginal Canadians and Canadians living in remote and rural areas.

We were told that, while Aboriginal Canadians have made impressive improvements in terms of health status, they remain at higher risk for illness, and earlier death than the Canadian population as a whole. They suffer from more chronic diseases such as diabetes and heart disease than the general population, and there is evidence that these conditions are increasing among Aboriginal groups. Similarly, Canadians in rural and remote localities usually have a lower health status than Canadians in urban areas. Further, they do not have access to the broad range of health services available in cities. The Committee was told that Canada has a special vantage point in dealing with rural and Aboriginal issues given our unique geography and multicultural make-up.

The Committee agrees with the assessment that Canada could become a world leader in these fields of research. Consequently, the Committee suggests that, in establishing the research institutes, the Governing Council of the Canadian Institutes of Health Research pay special attention to the specific health

ANNEXE

Projet de loi C-13, Loi portant création des Instituts de recherche en santé du Canada, abrogeant la Loi sur le Conseil de recherches médicales et modifiant d'autres lois en conséquence

Observations du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie

Pendant les audiences du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie sur le projet de loi C-13, Loi portant création des Instituts de recherche en santé du Canada, abrogeant la Loi sur le Conseil de recherches médicales et modifiant d'autres lois en conséquence, aucun témoin n'a parlé contre le projet de loi. Le Comité s'est fait dire que les Instituts de recherche en santé du Canada (les IRSC) élimineraient les obstacles traditionnels de discipline et de géographie au moyen de réseaux et de couplages «virtuels». On nous a également dit que ces instituts virtuels seraient de nature pluridisciplinaire et qu'ils favoriseraient l'intégration des quatre secteurs de la recherche en santé, à savoir la recherche biomédicale fondamentale, la recherche clinique appliquée, la recherche sur les systèmes de soins de santé et la recherche sur la santé de la population. Le Comité appuie vigoureusement cette approche innovatrice.

Tout en se montrant très favorables à la création des IRSC, les témoins ont fait quelques suggestions au sujet de la sélection des instituts de recherche. Le projet de loi C-13 prévoit la création de plusieurs instituts, mais il ne précise pas combien ni dans quels domaines de recherche. Ces décisions relèveront du conseil d'administration des IRSC. Un certain nombre de témoins ont insisté sur la nécessité d'accorder une attention particulière aux Canadiens autochtones et aux Canadiens des régions éloignées ou rurales.

On nous a dit que, bien que l'état de santé des Canadiens autochtones se soit remarquablement améliorée, ils courent un risque plus élevé de maladie et de décès prématuré que la population canadienne dans son ensemble. Ils souffrent davantage de maladies chroniques comme le diabète et la cardiopathie que l'ensemble de la population, et il y a lieu de croire que l'incidence de ces maladies augmente chez eux. De même, les Canadiens des régions rurales ou éloignées sont habituellement en moins bonne santé que ceux des régions urbaines et n'ont pas accès à tout l'éventail des services de santé offerts dans les villes. Les témoins nous ont dit que le Canada est éminemment bien placé pour examiner et régler les problèmes des populations rurales et autochtones en raison de sa géographie et de son caractère multiculturel uniques.

Le Comité estime lui aussi que le Canada pourrait devenir un chef de file mondial dans ces domaines de recherche. En conséquence, le Comité suggère que, au moment d'établir les instituts de recherche, le conseil d'administration des Instituts de recherche en santé du Canada porte une attention particulière aux

problems of Aboriginal Canadians and of Canadians living in rural and remote areas.

The Committee was also told that mental illness and mental health should be given special consideration under the CIHR. We heard that while 16 per cent of total health care costs are mental-health related, less than 5 per cent of research costs are applied to this area. Even though one in five Canadians will have a diagnosable mental illness that requires treatment, the stigma attached to mental illness has the effect of marginalizing a significant segment of our population. The Committee supports raising the profile and status of mental health issues within the medical and research community and, accordingly, suggests that the Governing Council of the Canadian Institutes of Health Research pay special attention to mental illness and mental health when establishing the institutes.

Furthermore, the Committee was told that, throughout their lives, women face life conditions and health issues specific to their biology and social circumstances and that, similarly, men face differential biological and social circumstances. Accordingly, witnesses stressed that gender-based analysis should be an integral part of health research. The Committee shares these views and, therefore, we suggest that gender analysis be incorporated in each of the institutes in order to reflect the health issues that have an impact on either women or men.

The Committee heard that the Centres for Excellence have stood as a centrepiece of the government's commitment to women's health research and are important milestones in the evolution of health research in this country. Moreover, the Committee is of the view that the role of the Centres for Excellence and that of the CIHR are not mutually exclusive and we encourage all research bodies to co-ordinate their efforts.

Witnesses stressed that health research requires transparent and credible ethical procedures, predominantly for the protection of human subjects of research. They welcomed clause 4(g), which fosters the application of ethical principles to health research. The Committee believes that ethics cross-cuts all sectors of health research and advocates the consideration of ethical issues in all CIRH research initiatives.

Finally, some witnesses discussed the organizational structure of the CIHR. More specifically, they raised concerns about Clause 9 of the bill, which states that the President of the CIHR would also be the Chairperson of the Governing Council. In order to ensure transparency and accountability of the CIHR, they contended that these two positions should be filled by different people. The Committee shares these concerns and

problèmes de santé propres aux Canadiens autochtones et aux Canadiens des régions rurales ou éloignées.

Le Comité s'est également fait dire que la maladie mentale et la santé mentale devaient bénéficier d'une attention particulière de la part des IRSC. Nous avons appris que bien que 16 p. 100 de la facture totale des soins de santé soient liés au traitement des maladies mentales, moins de 5 p. 100 des budgets de recherche sont affectés à ce domaine de la médecine. Même si un Canadien sur cinq souffrira d'une maladie mentale qui peut être diagnostiquée et qui nécessitera un traitement, la stigmatisation que laissent les maladies mentales a pour effet de marginaliser une partie considérable de notre population. Le Comité accueille donc l'idée de conférer aux questions relatives à la maladie mentale une plus grande importance et une priorité plus élevée dans le monde de la médecine et de la recherche médicale et, en conséquence, il suggère que le conseil d'administration des Instituts de recherche en santé du Canada porte une attention particulière à la maladie mentale et à la santé mentale au moment d'établir les instituts.

On a en outre dit au Comité que, tout au long de leur vie, les femmes connaissent des conditions de vie et des problèmes de santé liés à leurs particularités biologiques et à leur condition sociale et que, de la même façon, les hommes font face à des problèmes de santé spécifiques à la biologie et à des circonstances sociales qui leur sont propres. Aussi des témoins ont-ils souligné que l'analyse comparative entre les sexes devrait faire partie intégrante de la recherche en santé. Le Comité est aussi de cet avis et suggère que l'analyse comparative entre les sexes fasse partie intégrante du mandat de tous les instituts afin que chacun puisse tenir compte des facteurs qui ont une incidence sur la santé des femmes ou sur celle des hommes.

Le Comité s'est fait dire que les centres d'excellence constituent un vecteur privilégié de l'engagement pris par le gouvernement à l'égard de la recherche sur la santé des femmes et qu'ils sont des jalons importants de l'évolution de la recherche en santé au Canada. Le Comité estime de plus que leur rôle et celui des IRSC ne sont pas incompatibles et encourage tous les organismes de recherche à coordonner leurs activités.

Des témoins ont insisté sur la nécessité que la recherche en santé obéisse à un code d'éthique transparent et crédible, surtout pour assurer la protection des sujets humains de l'expérimentation. Ils ont applaudi l'alinéa 4g), qui encourage à appliquer les principes de l'éthique à la recherche en matière de santé. Le Comité est d'avis que l'éthique a sa place dans tous les secteurs de la recherche en santé et exhorte les IRSC à examiner toutes les questions d'ordre éthique que soulèvent leurs recherches.

Enfin, certains témoins ont critiqué la structure organisationnelle des IRSC. Ils se sont notamment dits préoccupés par l'article 9 du projet de loi, selon lequel le président des IRSC serait aussi président de leur conseil d'administration, affirmant qu'il serait préférable de confier ces deux postes à deux personnes différentes afin d'assurer la transparence et la responsabilité des IRSC. Partageant leurs

therefore we urge the federal government to amend the act at the end of the President's first five year term so that the position of President of the CIHR and the Chairperson of the Governing Council cannot be occupied simultaneously by the same person.

craintes, le Comité demande instamment que le gouvernement fédéral modifie la *Loi* à la fin du premier mandat de cinq ans du président des IRSC en y prévoyant qu'une même personne ne peut cumuler les fonctions de président des IRSC et de président de leur conseil d'administration.

EVIDENCE

OTTAWA, Thursday, April 6, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill C-13, to establish the Canadian Institutes of Health Research, to repeal the Medical Research Council Act and to make consequential amendments to other Acts, met this day at 11:08 a.m. to give consideration to the bill, and to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: We are back with our last set of witnesses on Bill C-13. Mr. David Hill will begin.

Mr. David Hill, President, Council for Health Research in Canada: We are here representing the Council for Health Research in Canada. Our organization is somewhat unique in that it is composed of several national health charities, such as cancer, heart, stroke and so on, and that is combined with most of the major health research institutes in this country.

We are here to tell you that we are supportive of this legislation that is before you. We have been involved in the evolution of the legislation. We supported it before the House of Commons committee, and we are here to do the same thing before your committee.

I would now turn our comments over to Dr. Ron Worton, who heads one of the research institutes that comprise our members. He is a member of the interim governing council of CIHR and has been closely involved in the development of the whole process, including the legislation.

Dr. Ronald Worton, Director of Research, Council for Health Research in Canada: Thank you, honourable senators, for this opportunity to meet with you today.

Although I have been a member of the interim governing council, my remarks today are not so much from the point of view of an interim governing council member as they are from that of the health research community. As director of a large research institute, and former chairman of the large department of genetics at Toronto's Hospital for Sick Children, I come to you representing researchers across the country.

The first point I should like to make is that this is probably the most exciting thing that has happened in medical research and health research since the creation of the Medical Research Council in 1960. The buy-in from the scientific community is enormous. I am sure you will recognize that there was some scepticism at the beginning about the creation of CIHR. That scepticism and unease was related more to the loss of MRC, which has been our line of support for so many years.

TÉMOIGNAGES

OTTAWA, le jeudi 6 avril 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie, qui a reçu pour mandat d'étudier le projet de loi C-13, Loi portant création des Instituts de recherche en santé du Canada, abrogeant la Loi sur le Conseil de recherches médicales et modifiant d'autres lois en conséquence, se réunit aujourd'hui à 11 h 08 pour étudier le projet de loi et examiner l'état du système de soins de santé au Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Nous entendrons ce matin notre dernier groupe de témoins au sujet du projet de loi C-13. M. David Hill a d'abord la parole.

M. David Hill, président, Conseil pour la recherche en santé au Canada: Nous représentons ici le Conseil pour la recherche en santé au Canada. Notre organisation est quelque peu unique en ce sens qu'elle est composée de plusieurs organismes nationaux de bienfaisance dans des domaines liés à la santé, comme le cancer, les maladies du cœur et d'autres maladies, et nous avons des liens avec la plupart des grands instituts de recherche en santé du pays.

Nous sommes venus vous dire que nous appuyons cette mesure législative dont vous êtes saisis. Nous avons suivi l'évolution du projet de loi. Nous l'avons appuyé devant le comité de la Chambre des communes et nous sommes ici pour faire de même devant votre comité.

Je donnerai maintenant la parole au docteur Ron Worton, qui dirige l'un des instituts de recherche membres de notre organisation. Il fait partie du conseil d'administration intérimaire des Instituts de recherche en santé du Canada (IRSC) et il a participé étroitement à tout le processus, y compris à la préparation du projet de loi.

Dr Ronald Worton, directeur de la recherche, Conseil pour la recherche en santé au Canada: Merci, honorables sénateurs, de nous donner cette occasion de vous rencontrer aujourd'hui.

Je suis membre du conseil d'administration intérimaire, mais ce n'est pas tellement à ce titre que je vous présente mes remarques aujourd'hui. Je vous parlerai plutôt du point de vue du milieu de la recherche en santé. À titre de directeur d'un grand institut de recherche et d'ancien président du grand département de génétique au Hospital for Sick Children de Toronto, je parle au nom des chercheurs de toutes les régions du pays.

Je tiens d'abord à vous dire que c'est probablement l'événement le plus passionnant qui se soit produit dans le domaine de la recherche médicale et de la recherche en santé depuis la création du Conseil de recherches médicales (CRM) en 1960. Le projet a maintenant rallié tous les milieux scientifiques. Vous reconnaîtrez sûrement qu'un certain scepticisme s'est manifesté au début au sujet de la création des IRSC. Ce scepticisme et ce malaise étaient plutôt liés à la perte du CRM, qui avait représenté pendant tant d'années notre soutien essentiel.

Now that the CIHR agenda is better understood, all the position papers are out describing how it will function. The scientific community has had input into the process and there has been an enormous buy-in across the spectrum. This initiative is driven, to a large extent, by scientists themselves as well as by the imperative to do more and better research. Moreover, this truly is transformative.

The Medical Research Council has been, to some extent, a reactive application. People would write grant applications and then submit those applications, and the best ones would be funded. That process has worked extremely well and has led to some of the best science in the world taking place in Canada. The CIHR adds to that. That is to say, it allows that process to continue to function. However, it also allows the development of a proactive agenda by creating institutes that have tremendous expertise in certain areas. It allows those institutes, through their advisory boards, to help shape and determine the research agenda for the country.

That has two important consequences. First, those expert bodies in each institute should be able to anticipate health threats and opportunities for research. I am quite convinced that, had we had a CIHR with an institute structure in the past, some of the problems we experienced dealing with HIV contamination and hepatitis C, and so on, could have been more easily dealt with by a proactive research agenda. So, secondly, this allows Canada to take a new approach to research, to fund the best research possible through its institute structure, and, at the same time, develop a proactive research agenda for the country. Thirdly, it will be more enabling because it is broader based. It includes all areas of health research, whereas the Medical Research Council of Canada was less broadly based. That will have tremendous importance for interdisciplinary research. Already, even in this interim period with a transition year, we see new research programs developing — that is, interdisciplinary programs with basic biomedical scientists working together with clinical scientists who are working together with people in the community and in the social services community to develop new and innovative research programs that could not have occurred nearly so easily without the creation of CIHR.

You will see new and better research, more collaborative research, and more integration of the social, ethical and legal considerations related to the research enterprise incorporated into the whole research agenda.

Those were my main points. I would be happy to take questions at this time.

Maintenant que l'on comprend mieux le projet des IRSC, on a une foule d'exposés de position qui décrivent comment le tout fonctionnera. Les milieux scientifiques ont participé au processus, qui reçoit maintenant l'appui de l'ensemble des chercheurs dans les domaines concernés. Cette initiative est impulsée, dans une grande mesure, par les scientifiques eux-mêmes aussi bien que par le besoin impérieux de faire plus de recherches et d'en faire de meilleures. De plus, cette initiative transforme vraiment notre façon de faire les choses.

Le Conseil de recherches médicales fonctionnait dans une certaine mesure en réaction à des demandes. Les gens remplissaient des demandes de subventions et les présentaient, et les meilleurs projets étaient financés. Ce processus a fonctionné extrêmement bien et nous a permis de réaliser au Canada des projets de recherche parmi les meilleurs au monde. Les IRSC nous permettront de faire encore plus. C'est-à-dire que le processus pourra continuer à fonctionner. Cependant, il y aura en plus un programme proactif, car on créera des instituts qui auront énormément d'expérience dans certains domaines. Ces instituts, grâce à leurs conseils consultatifs, concevront et élaboreront le programme de recherche du pays.

Cela aura deux conséquences importantes. Premièrement, les organes d'experts de chaque institut devraient pouvoir anticiper les menaces pour la santé et les possibilités de projets de recherche. Je suis absolument convaincu que si nous avions eu dans le passé une structure d'institut comme les IRSC, certains des problèmes que nous avons connus en ce qui concerne la contamination par le VIH et l'hépatite C, et d'autres, auraient pu être plus facilement résolus grâce à un programme de recherche proactif. En outre, cette initiative permettra au Canada d'adopter une nouvelle approche face à la recherche, de financer les meilleurs projets de recherche possible grâce à la structure des instituts, tout en élaborant un programme de recherche proactif pour le pays. Troisièmement, l'initiative permettra de faire encore davantage à cause de sa base plus vaste, qui inclura tous les domaines de la recherche en santé, tandis que le Conseil de recherches médicales du Canada avait une base plus restreinte. Cela aura une importance énorme pour la recherche interdisciplinaire. Même pendant la période de transition en cours, une période d'un an, nous pouvons déjà voir de nouveaux programmes de recherche s'organiser — c'est-à-dire des programmes interdisciplinaires dans le cadre desquels des chercheurs en sciences biomédicales fondamentales et des cliniciens travailleront avec des membres de la collectivité et des travailleurs sociaux en vue de concevoir des programmes de recherche innovateurs qui n'auraient pas pu voir le jour aussi facilement sans la création des IRSC.

Vous verrez de nouveaux projets de recherche et de meilleurs projets, plus de recherche en collaboration, et une plus grande intégration des considérations de nature sociale, éthique et légale, dans les projets de recherche découlant de tout ce programme de recherche.

C'étaient là mes principaux arguments. Je serai heureux de répondre à vos questions.

Ms Penelope Marrett, National Voluntary Organizations Working in Health: We are pleased to be here to talk about Bill C-13, and the opportunities that this presents to Canadians in their health. The National Voluntary Organizations Working in Health support Bill C-13 and are pleased to see that it passed in the House of Commons a couple of weeks ago. We are excited about its implementation and wish to commend the government for responding to a recommendation that we made urging the federal government to invest up to \$500 million annually in health research.

[Translation]

As you already know, it has been confirmed on many occasions that Canadians view health as one of their biggest concerns. Many polls conducted over the years rate health as the number one priority for all Canadians. In 1998, a poll confirmed, moreover, that our public health system was one of the features that set us apart from other countries.

We recommend that the Act on Canadian Institutes of Health Research be proclaimed as passed by the House of Commons on March 22, 2000. This act is further to a promise made in the 1990 Speech from the Throne and in the federal budget of 1999.

To conclude, I would like to repeat my support for volunteer health organizations in Bill C-13. We are pleased to have been given the opportunity to assist in the development of CIHRs to date and we fervently hope that we will be able to play an active role in their development.

[English]

On a separate note, it is important to remember that national health charities contribute up to \$300 million a year to health research in this country. That is about the same amount that the Medical Research Council of Canada has in their budget annually. We hope to continue to support health research not only through funding health research but also by becoming very active in the implementation of the CIHR.

The Chairman: Before turning to Senator Carstairs, I should like to ask Dr. Worton a question that arises out of something he said. In fact, many other people have told us the same thing. I wish to understand exactly what would be possible under the CIHR that is not possible under the existing system.

One gets the impression that the CIHR is making possible a series of voluntary interdisciplinary links that, presumably, could have taken place without the CIHR, if people had been motivated to do it. Every witness we have heard from is in favour of the bill. That is not the problem. However, I am trying to understand this from an actual, pragmatic standpoint. Can you give me an illustrative example of what is possible now that would not have been possible before? Is it simply that people are having a change of heart or a change in attitude toward greater cooperation because of this change? What is the real pragmatic change here?

Mme Penelope Marrett, Associations nationales bénévoles oeuvrant dans le domaine de la santé: Nous sommes heureux d'être ici pour parler du projet de loi C-13 et des possibilités qu'il offre aux Canadiens en matière de santé. Les associations nationales bénévoles oeuvrant dans le domaine de la santé appuient le projet de loi C-13 et nous avons été heureux de le voir adopter à la Chambre des communes il y a quelques semaines. Sa mise en oeuvre nous enthousiasme et nous voulons féliciter le gouvernement d'avoir donné suite à notre recommandation, quand nous exhortions le gouvernement fédéral à investir jusqu'à 500 millions de dollars annuellement dans la recherche en santé.

[Français]

Comme vous le savez déjà, les Canadiens ont confirmé à maintes reprises que la santé comptait parmi leurs plus grandes préoccupations. Dans plusieurs sondages au fil des ans, la santé demeure au premier rang des priorités pour tous les Canadiens. En 1998, un sondage confirmait par ailleurs que notre système de santé public était une des caractéristiques qui nous distinguait des autres pays.

Notre recommandation est que la Loi sur les Instituts canadiens de recherche en santé soit promulguée telle qu'adoptée par la Chambre des communes le 22 mars 2000. Cette loi fait suite à une promesse énoncée tant dans le discours du Trône de 1999 que dans le budget fédéral de 1999.

À titre de conclusion, je tiens à réitérer l'appui des organismes bénévoles en santé au projet de loi C-13. Nous sommes heureux d'avoir eu l'occasion de contribuer au développement des ICRS jusqu'à ce jour et souhaitons vivement contribuer de façon très active à leur essor.

[Traduction]

Par ailleurs, il est important de se rappeler que les organismes nationaux caritatifs dans le domaine de la santé contribuent jusqu'à 300 millions de dollars par année à la recherche en santé au pays. C'est à peu près le même montant que le budget annuel du Conseil de recherches médicales du Canada. Nous espérons continuer d'appuyer la recherche en santé non seulement en finançant la recherche en santé, mais aussi en participant très activement à la mise en oeuvre des IRSC.

Le président: Avant de passer la parole au sénateur Carstairs, j'aimerais poser au docteur Worton une question qui découle de l'une de ses remarques. De fait, plusieurs autres témoins nous ont dit la même chose. Je veux comprendre exactement ce qu'il serait possible de faire sous le régime des IRSC et qui ne l'était pas en vertu du système actuel.

On a l'impression que les IRSC permettront une série de projets interdisciplinaires volontaires qui, il y a lieu de le croire, auraient pu se produire sans la création des IRSC, si les gens avaient été motivés. Tous les témoins que nous avons entendus sont en faveur du projet de loi. Là n'est pas le problème. Cependant, j'essaie de comprendre la situation d'un point de vue pratique. Pouvez-vous me donner un exemple de choses qui sont maintenant possibles et qui ne l'étaient pas auparavant? Est-ce simplement parce que les gens subissent un revirement, un changement d'attitude qui les amènera à coopérer davantage à cause de ce changement? Quel est le véritable changement dans la pratique?

Dr. Worton: You are absolutely right. The same model could have been followed and it could have been called the CIHR, with the exception of the broadening into health research. That required a new name.

When the networks of centres of excellence were announced and created as a program back in the late 1980s, that was the first opportunity that Canadian researchers had to network. Sometimes, that kind of networking must be driven from above. That is to say, people must be provided with an opportunity to do that.

I was one of three people who put together an application to create a genetics disease network, which has been in existence since 1989. When we first met, most of us did not know one another. We often knew the names but did not know the faces. By the time that network had been in existence for four years, 40 per cent of the publications coming from that network were collaborative efforts that contained names of more than one network member. That level of collaboration might have been 5 per cent before that network happened. Putting in place the structure to allow that to happen was a good thing.

I might add that, when we had our network reviewed by European and American scientists as part of the review process at the end of four years, the Americans simply shrugged and said that they could never do that in the United States because there are too many scientists in every discipline to be able to collaborate. We had 40 scientists; the equivalent in the United States would have been 400. They said, "We could never do that, because we have too many in one field and we are too competitive with one another, but we like what you are doing in Canada."

The Chairman: To that extent, the silos get broken down. I use the term "silos" only because it applies to the way a lot of academic disciplines work. You are saying that changing the structure, to formally recognize the fact that collapsing the silos is a good thing, is essentially a motivator, even though, had people been motivated similarly from the beginning, they could have done it without changing anything?

Dr. Worton: That is right.

The Chairman: To that extent, structural change has a psychological impact as well as an organizational impact.

Dr. Worton: It has already had a psychological impact.

The other difference is that, by organizing into institutes that have well-defined expertise — for example, an institute for cardiovascular disease, if that is one of the institutes that is named — the advisory committee for that specialized institute will be able to identify opportunities and health threats in that area.

They will likely have an annual meeting where the scientists funded through that institute will get together and, in a way, have the same effect that other networks have had in the past. However, all of the scientists in the country will belong to one or the other of these institutes.

M. Worton: Vous avez absolument raison. On aurait pu suivre le même modèle et lui donner l'appellation IRSC, sauf qu'on n'aurait pas élargi les domaines de recherche en santé. Une telle initiative nécessitait un nouveau nom.

Lorsqu'on a annoncé la création des réseaux de centres d'excellence vers la fin des années 1980, c'était la première occasion pour les chercheurs canadiens de faire du réseautage. Il faut parfois qu'un réseautage de cette nature soit actionné par le haut. C'est-à-dire qu'il faut donner aux gens l'occasion de le faire.

J'ai fait partie d'un groupe de trois personnes qui ont conçu ensemble un programme pour créer un réseau sur les maladies et la génétique, qui existe depuis 1989. Avant de nous réunir pour la première fois, nous ne nous connaissions pas. Nous connaissions nos noms, dans certains cas, mais nous ne nous étions jamais rencontrés. Après quatre ans d'existence, 40 p. 100 des publications qui provenaient du réseau étaient le résultat d'efforts de collaboration entre au moins deux membres du réseau. Le niveau de collaboration avant la création du réseau aurait pu être de l'ordre de 5 p. 100. C'était donc une bonne chose de mettre cette structure en place.

Je peux ajouter que lorsque des scientifiques européens et américains ont étudié notre réseau dans le cadre d'un processus d'examen à la fin de la période de quatre ans, les Américains ont simplement haussé les épaules et dit qu'ils ne pourraient jamais faire cela aux États-Unis parce qu'il y a trop de spécialistes dans chaque discipline pour qu'ils puissent collaborer. Nous avions 40 scientifiques; l'équivalent aux États-Unis aurait été de 400. Ils ont dit: «Nous ne pourrions jamais faire comme vous, parce que nous avons trop de spécialistes dans un domaine et nous sommes trop compétitifs, mais nous aimons ce que vous faites au Canada.»

Le président: Dans cette mesure, le cloisonnement disparaît. Je parle de «cloisonnement» seulement parce que c'est ainsi que les choses fonctionnent dans de nombreuses disciplines. Vous dites que le fait de changer la structure, de reconnaître officiellement que l'élimination du cloisonnement est une bonne chose, constitue essentiellement un facteur motivant, bien que si l'on avait pu trouver un moyen de les motiver dès le début, les gens auraient pu le faire sans qu'on change la structure.

M. Worton: C'est exact.

Le président: Le changement de structure a donc ici un effet psychologique aussi bien qu'un effet sur le plan de l'organisation.

M. Worton: Il a déjà eu un effet psychologique.

L'autre différence vient du fait qu'en organisant la structure en instituts qui ont une spécialisation bien définie — par exemple, un institut des maladies cardio-vasculaires, si c'est l'un des instituts qui sont nommés — le comité consultatif de cet institut spécialisé sera en mesure d'identifier des possibilités de recherche et des menaces à la santé dans ce domaine.

On tiendra probablement une assemblée annuelle où les scientifiques financés par l'entremise de l'institut se rencontreront et pourront faire d'une certaine façon la même chose que d'autres réseaux ont permis de faire dans le passé. Cependant, tous les scientifiques du pays appartiendront à l'un ou l'autre de ces instituts.

The Chairman: As a layperson, I thought that had already happened.

Senator Carstairs: I will direct my first question to Ms Marrett, who has brought to the table this morning a position that was not clearly enunciated before today. There is a tendency to view this through a prism and determine that only the CIHR will contribute to research in Canada. Was \$300 million the figure used?

Ms Marrett: That is right.

Senator Carstairs: Where is that \$300 million directed primarily? Is it to cancer or heart research?

Ms Marrett: I do not have the breakdown of that figure. It was in a report from Statistics Canada, which did some research on this about eight months ago. However, I know that the National Cancer Institute of Canada, the Canadian Cancer Society, is one of the largest funders of cancer research in this country. We do not have a definitive breakdown. However, the amount does cover a number of different areas. To our knowledge, it is not just disease specific; it is an approximation based on a survey that was done, so we know that it is not complete. Many of the national health charities that are disease specific do fund health research in their particular areas. They are able to fund not only bio-medical, but a whole range of health research, such as psycho-social, among others. They fund some areas far more than others, depending, of course, on their ability to provide the funds for the research.

Senator Carstairs: My other question has nothing to do with Bill C-13, but I am curious. How do you make a particular disease "sexy" in terms of its being able to acquire research dollars? A friend and I have had some discussions about the issue and, quite frankly, we realize that women have generated a great deal of money for breast cancer research, whereas men, because they cannot seem to talk about prostate disease, have not been able to generate the same kind of research dollars. A group of us, whose husbands have had prostate cancer, have decided we should make it a women's issue. How do we generate comparable interest for prostate cancer?

Ms Marrett: That is a huge challenge. For any disease, there are several different factors that help to form the whole mould. One factor can be the media and what they do or do not do. How much will the media come on side? How much can you talk about the issue publicly and frankly? How much does the Canadian public want to hear about the issue?

Le président: Je suis un simple profane et je pensais que c'était déjà fait.

Le sénateur Carstairs: Je veux poser ma première question à Mme Marrett, qui nous a présenté ce matin une position que nous n'avions pas encore entendu énoncer clairement avant aujourd'hui. On a tendance à voir ce projet à travers un prisme et à penser que seuls les IRSC contribueront à la recherche au Canada. Vous avez bien utilisé le chiffre de 300 millions de dollars?

Mme Marrett: En effet.

Le sénateur Carstairs: Où vont principalement ces 300 millions de dollars? Sont-ils consacrés à la recherche sur le cancer ou les maladies cardiaques?

Mme Marrett: Je n'ai pas de ventilation. Ce chiffre figurait dans un rapport de Statistique Canada qui a effectué des recherches à ce sujet il y a environ huit mois. Cependant, je sais que l'Institut national du cancer du Canada, la Société canadienne du cancer, est l'organisme qui contribue le plus au financement de la recherche sur le cancer au pays. Nous n'avons pas de ventilation précise. Toutefois, ce montant concerne un certain nombre d'activités différentes. À notre connaissance, il ne s'agit pas seulement de sommes destinées à des maladies précises, c'est une estimation fondée sur une enquête statistique et nous savons donc que le résultat n'est pas complet. Plusieurs des organismes nationaux de bienfaisance dans le domaine de la santé qui se préoccupent d'une maladie donnée, financent en effet la recherche dans le domaine qui les intéresse. Ils peuvent financer non seulement la recherche biomédicale, mais toute une gamme de projets de recherche en santé portant par exemple sur l'aspect psycho-social de la maladie. Ils financent certains domaines plus que d'autres, tout dépendant évidemment de leur capacité de fournir des fonds pour la recherche.

Le sénateur Carstairs: Mon autre question n'a rien à voir avec le projet de loi C-13; je suis seulement curieuse. Comment vous y prenez-vous pour rendre une certaine maladie «sympa» afin de pouvoir attirer des dollars pour la recherche? Une amie et moi avons discuté de la question et je vous le dis franchement, nous avons constaté que les femmes avaient réussi à recueillir énormément d'argent pour la recherche sur le cancer du sein, alors que les hommes n'ont pas réussi à en recueillir autant, parce qu'ils ne semblent pas disposés à parler des maladies de la prostate. Certaines d'entre nous, dont le mari a souffert du cancer de la prostate, ont décidé qu'il fallait en faire une question qui concerne les femmes. Comment pouvons-nous susciter un intérêt comparable pour le cancer de la prostate?

Mme Marrett: C'est un défi énorme. Pour toute maladie, il y a plusieurs facteurs différents qui contribuent à former un programme complet. Les médias peuvent être l'un de ces facteurs, mais cela dépend de ce qu'ils sont disposés à faire. Dans quelle mesure les médias accepteront-ils de participer? Dans quelle mesure peut-on parler publiquement et franchement de la question? Dans quelle mesure la population canadienne veut-elle entendre parler de la question?

I know that a Canadian prostate cancer organization exists and is working with the Canadian Cancer Society and the CIC in collaboration on a number of different things, but as to popularising it I cannot tell you how best to do that. For some of the smaller disease groups that have the same struggles it is not very easy, but oftentimes it is necessary to get everyone on side within the community. That is one of the biggest challenges.

The Chairman: I would like to hear Dr. Worton's point of view as someone who is interested in receiving funds. How can a disease that is not "fashionable" become so in terms of fundraising? I compare that with an issue such as sick children, which is automatically "fashionable".

Dr. Worton: That is one question that I did not anticipate. However, I can say that prostate cancer is now a smaller problem than it was, because the breast cancer initiative has increased the awareness of prostate cancer and there are new major research programs addressing prostate cancer. It is also a matter of timing, because some genes have recently been identified that are responsible for prostate cancer. That opportunity opens up a new field of research.

I have been associated with the Muscular Dystrophy Association of Canada for many years and I am currently the vice-chairman of the board. We fight that "awareness" problem constantly. One of the ways to raise awareness is to make use of the influence of high profile individuals. For example, in the United States Gerry Lewis takes on this task. It is debatable whether or not he is the right person, but he has brought enormous support to muscular dystrophy research. In Canada we have had a series of different people. If it is possible to capture a well-recognized person, such as sports figure Kurt Browning, who was our Honorary Chairman for two or three years, an enormous amount of support can be garnered for an organization.

The Chairman: What has been described is a classic marketing problem, and I do not mean to be pejorative when I say that; but that is what it takes to capture the attention of the public.

Senator Carstairs: My second question has to do with a possible conflict concerning the president of the CIHR and the chairman of the interim governing council being one and the same person. Do you have any difficulty with that? If so, why? If not, why not?

Dr. Worton: I will address that first, if I may. It is certainly an issue that was discussed at great length in the interim governing council when preparing the first draft of this legislation. I believe that there are pros and cons. Some of the health charities have had the view that there should be a separation of power as between the president and the chair, but, although there was not unanimity around the table of the IGC, in the end a consensus to have one person acting was created. One of the reasons for having one

Je sais qu'il existe une organisation canadienne pour le cancer de la prostate et qu'elle travaille avec la Société canadienne du cancer et l'Institut du cancer du Canada en collaboration avec un certain nombre d'autres organismes, mais je ne peux pas vous dire quelle est la meilleure façon de «mettre en vogue» cette maladie. Ce n'est pas très facile pour certains groupes qui s'occupent d'une maladie moins fréquente et qui sont aux prises avec les mêmes problèmes, mais il est souvent nécessaire de faire participer tout le monde dans la collectivité. C'est l'un des plus grands défis.

Le président: J'aimerais entendre le point de vue du docteur Worton en sa qualité de personne qui aimerait recevoir des fonds. Comment une maladie qui n'est pas «à la mode» peut-elle le devenir au niveau du financement privé? Je compare cela à un phénomène comme celui des enfants malades, qui est automatiquement «à la mode».

M. Worton: Je ne m'attendais à pas cette question-là. Cependant, je peux dire que le cancer de la prostate est aujourd'hui un problème moins aigu qu'il ne l'était étant donné que l'initiative relative au cancer du sein a accru la sensibilisation au cancer de la prostate, et il existe maintenant de nouveaux grands programmes de recherche qui s'intéressent au cancer de la prostate. C'est aussi une question d'opportunité étant donné que l'on a récemment découvert certains gènes qui sont responsables du cancer de la prostate. Cette découverte a ouvert un nouveau champ de recherche.

J'ai été associé pendant plusieurs années à l'Association canadienne de la dystrophie musculaire, et je suis actuellement vice-président du conseil d'administration. Nous sommes constamment aux prises avec ce problème de la «sensibilisation». On peut accroître la sensibilisation entre autres choses en utilisant l'influence de personnalités très connues. Par exemple, aux États-Unis, Jerry Lewis joue ce rôle. On peut contester le choix de cette personne, mais le fait est qu'il a énormément contribué à faire avancer la recherche sur la dystrophie musculaire. Au Canada, nous avons eu une série de personnes différentes. Il est possible de recruter une personnalité bien connue, par exemple le patineur Kurt Browning, qui a été notre président honoraire pendant deux ou trois ans, et une organisation peut ainsi recueillir des appuis très considérables.

Le président: C'est ce qu'on a décrit comme étant un problème de marketing classique, et je ne l'entends pas au sens péjoratif, mais c'est ce qu'il faut pour capter l'attention du public.

Le sénateur Carstairs: Ma deuxième question a trait au conflit que pourrait poser le fait que le président des IRSC et le président du conseil d'administration intérimaire soient la même personne. Vous opposez-vous à cela? Si oui, pourquoi? Si non, pourquoi pas?

M. Worton: Je vais répondre à cela en premier, si vous le permettez. C'est certes une question qui a été longuement débattue au sein du conseil d'administration intérimaire lorsqu'on a préparé la première mouture de ce projet de loi. Je pense qu'il y a des arguments pour et contre. Certaines oeuvres de bienfaisance oeuvrant dans le domaine de la santé étaient d'avis qu'il fallait qu'il y ait séparation des pouvoirs entre le président du conseil d'administration et le président des IRSC mais, même s'il n'y

person act as the president and the chair is that this is a government-funded organization and there must be a direct responsibility to the Minister of Health. That could be problematic if the positions were filled by two individuals.

My own view is that this is the best model to follow, and that was certainly the consensus of the IGC in drafting the legislation.

Senator Robertson: Returning to the issue of the \$300 million that was referred to — and I suppose there is about the same amount of money in the new body — I have always been astounded and a bit concerned at the lack of cooperation among research groups. One never seems to know what the other is doing; I hope that somehow or other the new Canadian Institutes of Health Research will be able to develop a cooperative attitude among all researchers in the country, because, if we do not have that cooperation, we are wasting dollars.

A number of years ago, I had a medical intern in the office one summer. I wanted him to do some work with the voluntary organizations to see what cooperation existed. I will take as an example, research on anti-rejection drugs for transplantation procedures in heart, kidney, liver, vision, et cetera. Everyone seemed to be working in different directions with little coordination. I thought, "What a shame. What a waste of the public's money contributed to all those organizations."

I do not know if that has been fixed, because I have not followed up on it since that summer's work, but I believe that, somehow, we have to stop wasting research money through lack of coordination and cooperation among the different parts.

I know that there is a "protection of property" issue, and an attitude of "I don't want you to know what I am doing, because I am on to something good and maybe I will get there before you do". I would add to that, what I would call in street language, the commercial research that is going on in Canada.

Do we see any opportunity for a coordinated approach? Can we reach out with this new structure to have more coordination? You expressed that you already could see the coordination, but what about those outside your institutes? Is there any way that you can connect with those people? I have heard, and I am sure most of us around the table have heard, people grumbling about giving to so many groups.

There is certainly duplication, and some members of the public think that there is quite a little waste going on, because the public is catching on to this fact that there is a lack of coordination and a lack of cooperation. I hope I am totally wrong. I hope I am not being too rough on the systems. I feel uncomfortable about it.

I should like comments from both groups.

avait pas unanimité au sein du conseil d'administration intérimaire, on s'est entendu à la fin pour désigner une seule personne. Si l'on a décidé que le président du conseil et le président seraient la même personne, c'est entre autres choses parce qu'il s'agit d'une organisation financée par l'État, et que le président doit rendre compte directement au ministre de la Santé. Cela pourrait faire problème si les deux postes étaient occupés par deux personnes.

À mon avis, c'est le meilleur modèle qui soit, et il y avait certainement consensus au sein du conseil d'administration intérimaire lorsqu'on a rédigé le projet de loi.

Le sénateur Robertson: Pour en revenir à la question des 300 millions de dollars que l'on a mentionnés — et j'imagine que c'est à peu près le même montant d'argent pour ce nouvel organisme — j'ai toujours été étonnée et quelque peu préoccupée par l'absence de coopération entre les groupes de recherche. On dirait que personne ne sait jamais ce que l'autre fait; et j'espère qu'avec la création des Instituts de recherche en santé du Canada, on pourra susciter une attitude de coopération entre tous les chercheurs du pays parce que sans cette coopération, nous gaspillons notre argent.

Il y a plusieurs années de cela, j'avais un médecin stagiaire dans mon bureau pendant l'été. Je voulais qu'il travaille avec les associations bénévoles pour voir quel était le niveau de coopération. Je vais citer à titre d'exemple la recherche sur les médicaments anti-rejet pour les transplantations du coeur, des reins, du foie, des yeux, et cetera. Chacun semblait travailler de son côté, avec peu de coordination. Je me suis dit: «C'est une honte. Comme l'on gaspille l'argent que le public verse à ces organisations».

Je ne sais pas si l'on a réglé ce problème parce que je n'ai pas suivi ce dossier depuis cet été-là, mais je crois que, d'une manière ou d'une autre, il faut cesser ce gaspillage des crédits de recherche que cause l'absence de coordination et de coopération entre les divers éléments en cause.

Je sais qu'il se pose un problème relatif à la «protection de la propriété», et il y a aussi cette attitude qui consiste à dire: «Je ne veux pas que vous sachiez ce que je fais parce que je suis sur une bonne piste, et je vais peut-être ainsi vous coiffer au poteau.» J'ajouterais à cela ce que j'appellerais, en termes familiers, la recherche commerciale qui se pratique au Canada.

Y a-t-il moyen d'établir une approche coordonnée? Cette nouvelle structure favorisera-t-elle la coordination? Vous avez dit que vous pouviez déjà voir une coordination, mais qu'en est-il à l'extérieur de vos instituts? Vous est-il possible de rejoindre ces personnes? J'ai entendu des personnes qui grognaient parce que l'on donne à tellement de groupes, et j'ai la certitude que la plupart d'entre nous ici présents ont entendu la même chose.

Chose certaine, il y a double emploi, et certains citoyens pensent qu'il se fait beaucoup de gaspillage parce que le public commence à se rendre compte de cette absence de coordination et de coopération. J'espère me tromper totalement. J'espère que je ne suis pas trop injuste. Ce sujet me met mal à l'aise.

J'aimerais entendre l'opinion des deux groupes.

Ms Marrett: There is a great deal more cooperation going on with national health charities now than there ever has been. One reason that that has occurred is that during the last five years or so national health charities themselves have seen the need to cooperate on their common issues. They have actually come together on three common issues — health research, health information and surveillance, and community patient support. They are in the midst now of talking about how to develop an alliance in order to become much stronger in their cooperative work.

One of the areas that they have talked about, interestingly enough, is the sharing of funding. Due to the advances that have occurred in research, oftentimes the researchers who apply for funding have already had an impact on something else. So the organizations are talking about how to ensure that we cooperate even more. We have a workshop coming up in mid-April to talk about this in more detail.

When the CIHR gets established, which we hope it will be, we will also work with the CIHR on ways to ensure that that cooperation continues, not just with ourselves as health charities, but with the whole research community itself. I am optimistic that that will occur more and more.

That is not to say that any of the organizations would stop requesting funds from the public to support the work that they do, and they do a lot of different work, because part of that work supports health research, but not all of it. There is always a need to respect what a community's responses are to their own community.

Senator Robertson: If you have printed information on that improved cooperation, I would certainly appreciate receiving some of it.

Dr. Worton, is there any way we can reach out to the commercial researchers, or are they totally silent?

Dr. Worton: The Medical Research Council of Canada, several years ago, initiated a series of partnerships with the industry, with pharmaceutical manufacturers, with the biotech industry and so on, to jointly fund research efforts. That is ongoing that has been recently renewed and expanded. That will continue under the CIHR.

The benefits of those partnerships work in both directions, actually. You bring commercial dollars in to help the research, taking some of the burden off government. At the same time, when they put dollars in they expect something in return in the way of access to the intellectual property and the information. Therefore, they can take advantage of that in developing their own businesses.

That is a mutually good thing to do, and it has been so recognized for a long time. That will continue.

With regard to the health charities, I could give you one example. My information is more anecdotal than global, but having been with the muscular dystrophy organization, I know that that organization has been at loggerheads with the ALS

Mme Marrett: Il y a aujourd'hui beaucoup plus de coopération entre les oeuvres de bienfaisance nationales oeuvrant dans le domaine de la santé que qu'auparavant. Il y en a plus que jamais. Il en est ainsi entre autres parce qu'au cours des cinq dernières années à peu près, les oeuvres de bienfaisance nationales ont elles-mêmes constaté la nécessité de coopérer dans les dossiers qu'elles avaient en commun. Elles se sont en fait entendues sur trois dossiers communs: la recherche en santé, l'information sur la santé et le contrôle, et le soutien communautaire aux patients. Elles discutent en ce moment de la création d'une alliance qui consoliderait de beaucoup leur coopération.

Chose intéressante, le partage du financement est l'une des questions dont elles ont discuté. Étant donné les progrès réalisés en matière de recherche, souvent, les chercheurs qui demandent du financement ont déjà eu un effet sur un autre secteur. Ces oeuvres nationales discutent donc de la manière dont elles pourraient coopérer encore plus. Nous allons tenir un atelier à la mi-avril pour discuter de cela plus avant.

Lorsque les IRSC seront créés, ce que nous espérons, nous allons également collaborer avec les IRSC pour assurer la poursuite de cette coopération, pas seulement avec nous, les oeuvres de bienfaisance nationales, mais aussi avec l'ensemble des chercheurs. J'ai la certitude que cela se fera de plus en plus.

Ce qui ne veut pas dire que l'une quelconque de ces organisations doit cesser de solliciter l'appui financier du public pour soutenir son oeuvre, car chacune fait un travail très différent étant donné qu'une partie de ce travail, mais pas tout, vient en aide à la recherche en matière de santé. Il faut toujours respecter ce que chacun fait dans son propre domaine.

Le sénateur Robertson: Si vous avez des informations sur cette coopération améliorée, j'aimerais certainement en recevoir.

Docteur Worton, y a-t-il moyen de rejoindre les chercheurs commerciaux, ou sont-ils totalement muets?

M. Worton: Le Conseil de recherches médicales du Canada, il y a quelques années, a entrepris une série de partenariats avec l'industrie, avec les pharmaceutiques, avec l'industrie biotechnologique et autres, pour financer conjointement des initiatives de recherche. Ces partenariats se poursuivent, et ils ont été récemment renouvelés et élargis. Cela continuera sous les auspices des IRSC.

En fait, ces partenariats sont mutuellement bénéfiques. Le secteur privé contribue financièrement à la recherche, ce qui soulage un peu l'État. Au même moment, s'il investit, il s'attend à un certain rendement qui prend la forme de l'accès à la propriété intellectuelle et aux informations. Il peut par conséquent en profiter pour créer ses propres entreprises.

C'est donc mutuellement profitable, et on le sait depuis longtemps. Cela va se poursuivre.

Pour ce qui est des oeuvres de bienfaisance nationales dans le domaine de la santé, je peux vous donner un exemple. Il s'agit davantage d'un témoignage personnel, mais ayant été associé à l'Association de la dystrophie musculaire, je sais que celle-ci s'est

society for years and years, because to some extent they raise funds for the same overlapping set of diseases. Over the last three years, those organizations have got together and created one single research-funding program. They jointly fund research, but not only do they do that, they have partnered with the Medical Research Council of Canada, which is putting in \$1 for every \$2 from the health charities.

Therefore, the Muscular Dystrophy Association's \$250,000 will be stretched into \$750,000 this year for one specific program. The two organizations are sitting at the same table. Having done that, they will now move into the same office and share space. One must believe that the next thing could be a merger.

Senator Robertson: That is good progress. Thank you for that information.

With the research that your groups and institutes are doing, what will happen when you have a product that eventually should be distributed to the general public? How do you intend to do that?

I was told yesterday that you were not interested in the commercial areas. However, how would you have that commercialization happen? Would it be through royalties? The University of Alberta has done that in a couple of instances.

Dr. Worton: All of the universities now have technology transfer offices that deal with those issues. They determine when an invention or product could be patented or is marketable. Patenting is one way to handle it. Secrecy is the other way. If you do not tell anybody, you do not need a patent.

The process is to patent and to publish. You publish the information, making it available to everyone. If a commercial enterprise wants to use that information or that product, they must pay for it.

That commercialization can be done in several ways. One way is a royalty back to the university or whatever. Another way is a licensing agreement with some up-front money for the privilege of licensing it. A third way would be to create a new company and provide the university or hospital with equity in that company. That was a less common mechanism in the past, but I suspect it will be more common in the future.

Senator Robertson: Through royalties, Mr. Chairman, we could almost replace the government money in 10 or 15 years to help this research move forward.

The Chairman: Your third model, the creation of a company, is what has been done with World Heart; is that correct?

Dr. Worton: Correct.

The Chairman: I understand that the Ottawa Heart Institute formed a company which is effectively owned in large part by the Heart Institute.

opposée pendant des années et des années à la société de la SLA parce que, dans une certaine mesure, les deux organisations sollicitent des fonds pour le même ensemble de maladies. Au cours des trois dernières années, ces organisations se sont unies et ont créé un programme unique de financement de la recherche. Elles financent conjointement la recherche, et non seulement cela, elles se sont associées au Conseil de recherches médicales du Canada, qui investit un dollar pour chaque deux dollars qu'elles investissent.

Par conséquent, les 250 000 \$ de l'Association canadienne de la dystrophie musculaire deviendront 750 000 \$ cette année pour un programme en particulier. Les deux organisations sont à la même table. Cela étant fait, elles vont maintenant occuper les mêmes locaux et partager des espaces de bureau. Il faut croire que la fusion pourrait être la prochaine étape.

Le sénateur Robertson: Voilà qui s'appelle un progrès. Je vous remercie de me l'avoir dit.

Étant donné que vos groupes et instituts menaient des recherches, qui se produira-t-il quand vous aurez découvert un produit que pourrait être distribué au grand public? Comment comptez-vous faire?

On m'a dit hier que le secteur commercial ne vous intéressait pas. Cependant, comment vous y prendriez-vous pour commercialiser ce produit? Est-ce que vous toucheriez des redevances? C'est ce que l'Université de l'Alberta a fait dans quelques cas.

M. Worton: Toutes les universités ont aujourd'hui des bureaux de transfert technologique qui s'occupent de ces questions. Ces bureaux décident à quel moment une invention ou un produit peut être breveté ou mis sur le marché. Le brevetage est une solution. Le secret en est une autre. Si vous ne dites rien à personne, vous n'avez pas besoin de brevet.

Le processus consiste à obtenir un brevet et à faire connaître votre invention. Vous publiez vos informations, vous les offrez à tous. Si une entreprise commerciale veut se servir de ces informations ou de ce produit, elle doit payer.

Cette commercialisation peut se faire de diverses manières. L'université ou l'organisation peut entre autres exiger des redevances. On peut aussi conclure un contrat de licence aux termes duquel on vous verse de l'argent au départ pour obtenir le privilège de la licence. Troisièmement, on peut créer une nouvelle entreprise et offrir des actions dans cette entreprise à l'université ou à l'hôpital. Ce mécanisme était moins courant par le passé, mais j'imagine qu'il sera plus répandu à l'avenir.

Le sénateur Roberston: En percevant des redevances, monsieur le président, on pourrait presque remplacer les crédits de l'État dans 10 ou 15 ans pour aider ces recherches à avancer.

Le président: Votre troisième modèle, la création d'une entreprise, c'est ce qu'on a fait avec World Heart, n'est-ce pas?

M. Worton: C'est exact.

Le président: Je crois savoir que l'Institut de cardiologie d'Ottawa a fondé une entreprise qui est en fait dans une large mesure la propriété de l'Institut de cardiologie.

Dr. Worton: I do not know about the ownership question, but certainly it was a spin-off from the Heart Institute.

The Chairman: They went that route rather than the royalty or up-front-payment routes.

Senator Callbeck: I have a question on the composition of the boards. We had several witnesses last night. One was Sharon Sholzberg-Gray, President and CEO of the Canadian Healthcare Association. She was recommending the inclusion of consumer or public representation on the governing council and other decision-making and priority-setting bodies of the CIHR.

As well, Ms Jeans, Executive Director of the Canadian Nurses Association, mentioned that the public must be involved in processes and governance of the CIHR, including participation in the proposed advisory boards. How important do you feel that it is to reach outside the research community?

Ms Marrett: From the perspective of National Voluntary Organizations Working in Health, which represents many Canadians across the country who live with particular diseases and disorders, either themselves personally or with their families, we consider this to be a very important issue. That is one of the reasons why we have been so pleased to be so involved with the development of the CIHR up to now. We look forward to being further involved with the implementation. We submitted some nominations to the government for the governing council, and we look forward to the announcement that will be made.

We believe that there are many different ways, though, of being involved, and there are different levels of decision-making. We do hope to see well-known Canadians on the governing council, and we do, also, expect that there will be public involvement at the institute advisory board level, as well as other decision-making levels. We are very confident that this will occur, and we are working closely with the CIHR implementation secretariat on some of these issues.

Senator Callbeck: Any other comments?

Dr. Worton: The process of selecting the governing council has been fairly open. We, as scientists, have been pleased with that, because there was a process of nomination. Some 400 people were nominated for positions on the governing council. I think it has now been through a committee structure, and the nominations have been brought down to a list of 40. Of that 40, 18 will be chosen. Two of the 20 positions are predetermined.

We are very pleased with that process. I am sure that there will be a mixture of scientists and well-known figures and smart people on that governing council.

What the balance will be, I guess, is not in the hands of the interim governing council, but rather in the hands of government at the moment.

M. Worton: J'ignore qui est propriétaire au juste, mais je sais de source sûre que c'est une création de l'Institut de cardiologie.

Le président: Il a préféré cette option aux redevances ou au paiement forfaitaire.

Le sénateur Callbeck: J'ai une question au sujet de la composition des conseils d'administration. Nous avons entendu plusieurs témoins hier soir, dont Sharon Sholzberg-Gray, présidente et chef de la direction de l'Association canadienne des soins de santé. Elle recommandait l'adjonction d'un représentant des consommateurs ou du public au conseil d'administration et aux autres instances des IRSC chargés de prendre des décisions et d'établir les priorités.

De même, Mme Jeans, directrice générale de l'Association des infirmières et des infirmiers du Canada, a dit que le public devrait prendre part à l'administration des IRSC, et cela comprenait dans son esprit la participation aux conseils consultatifs que l'on entend créer. Dans quelle mesure importe-t-il à votre avis de rejoindre les gens à l'extérieur du milieu de la recherche?

Mme Marrett: Du point de vue des Associations nationales bénévoles oeuvrant dans le domaine de la santé, qui représentent de nombreux Canadiens qui vivent dans toutes les régions du pays et qui sont atteints de maladies et de troubles particuliers, qu'il s'agisse d'eux-mêmes ou de membres de leur famille, nous considérons que c'est une question très importante. C'est l'une des raisons pour lesquelles nous étions si heureux de prendre part à la création des IRSC jusqu'à présent. Nous serons heureux également de prendre part à leur mise en oeuvre. Nous avons proposé au gouvernement des candidatures au conseil d'administration, et nous avons hâte que ces nominations se fassent.

Nous croyons cependant qu'il y a plusieurs façons de participer, et on sait qu'il y a divers niveaux décisionnels. Nous espérons que des Canadiens bien connus siégeront au conseil d'administration, et nous nous attendons aussi à ce que le public soit représenté au niveau des conseils consultatifs des instituts ainsi qu'au sein des autres instances décisionnelles. Nous avons la certitude que cela se fera, et nous travaillons en étroite collaboration avec le secrétariat chargé de la mise en oeuvre des IRSC dans certains de ces dossiers.

Le sénateur Callbeck: D'autres observations?

M. Worton: Le processus de sélection du conseil d'administration a été assez ouvert. Nous, en notre qualité de scientifiques, en sommes heureux, parce qu'il y a eu un processus de nomination. On a présenté près de 400 candidatures au conseil d'administration. Je crois qu'on a maintenant créé des comités, et on a établi une liste de 40 candidats. Sur ces 40, 18 seront choisis. Deux des 20 postes sont comblés à l'avance.

Nous sommes très heureux de ce processus. J'ai la conviction que l'on aura un mélange de scientifiques, de personnalités connues et de personnes intelligentes à ce conseil d'administration.

J'imagine qu'il n'appartient pas au conseil d'administration intérimaire mais plutôt au gouvernement en ce moment de déterminer la composition du conseil d'administration.

The Chairman: Thank you, witnesses, for being here this morning.

Honourable senators, since our hearings last night, the staff and I, together with the steering committee, have developed a draft report. I believe that was circulated to you.

Before I discuss that, I would just like to make reference to the fact that I received two letters this morning. One was from Mr. Harry Daniels, the President of the Congress of Aboriginal Peoples, which is the aboriginal organization that represents Métis and off reserve people. The point of Mr. Daniels' letter, which has been circulated to you, is that, effectively, in the development of medical research in relation to aboriginal issues, in particular with respect to the aboriginal health issue, the Congress of Aboriginal Peoples has been excluded from many of the discussions. The focus has been on the views of the three national aboriginal organizations, the Assembly of First Nations, the Inuit Taparissat and the Métis National Council.

If the committee agrees, when we are finished with the report, I should like to write a letter to Dr. Friesen, as chair of the interim governing council, enclosing Mr. Daniel's letter. I would point out to him that it is important that the views of off-reserve people, in particular, be reflected in the work of the CIHR.

Second, there is a letter from the Canadian Medical Research Organization that indicates their strong support for the bill, and talks about an office of "clinical excellence", which is not directly under the CIHR. Again, it would be my proposal to send this letter, along with my covering letter, to Dr. Friesen, if we agree on that.

With that further information, I would ask you to look at the draft report. Senator Carstairs, Senator LeBreton and I, as the three members of your steering committee, reviewed it earlier this morning. I would now open it to any questions or comments that anybody might like to make.

Senator Carstairs: I did mention this concern to the steering committee, and that is specifically why I raised the matter with the last group of witnesses. In the final paragraph, it says:

The committee shares these concerns and therefore we urge the federal government to amend the act at the end of the President's first five year term...

I would really like to see us change that so that it says "seriously consider amending the act". We heard today that there might indeed be a conflict in reporting to the Minister of Health, if we divided these two positions between the chair and the president.

The Chairman: Let me give the other side. This is an issue where you and I are on opposite sides.

Much of the work that has been done on the governance of institutions of all kinds, for-profit, not-for-profit, and government institutions, has made that argument. I must say that the Banking Committee looked at this with everything ranging from the board that is managing CPP funds, through to corporations, through to

Le président: Je remercie les témoins d'avoir été des nôtres ce matin.

Chers collègues, depuis notre séance d'hier soir, le personnel et moi-même, de concert avec le comité directeur, avons formulé l'ébauche d'un rapport. Je crois que vous en avez reçu copie.

Avant d'en discuter, j'aimerais seulement vous signaler que j'ai reçu deux lettres ce matin. L'une de M. Harry Daniels, président du Congrès des peuples autochtones, l'organisation autochtone qui représente les Métis et les Amérindiens hors réserve. M. Daniels fait valoir dans sa lettre, qui vous a été remise, qu'en fait, pour ce qui est de la recherche médicale relative aux questions autochtones, particulièrement relativement à la santé des Autochtones, le Congrès des Peuples Autochtones a été exclu d'une bonne partie des discussions. On a surtout entendu trois organisations nationales autochtones, soit l'Assemblée des premières nations, l'Inuit Tapirisat et le Métis National Council.

Si le comité le veut bien, lorsque nous en aurons terminé avec le rapport, je vais écrire au docteur Friesen, le président du conseil d'administration intérimaire, et je vais annexer à ma lettre celle de M. Daniels. Je lui dirai qu'il lui faut entendre les vues des Amérindiens hors réserve, en particulier, et que celles-ci doivent être prises en compte dans les travaux des IRSC.

Deuxièmement, nous avons une lettre de l'Association de recherche médicale canadienne qui se dit très favorable au projet de loi et parle de la création d'un bureau d'«excellence clinique», qui ne relève pas directement des IRSC. Encore une fois, je propose d'annexer cette lettre à ma lettre au docteur Friesen, si nous sommes d'accord.

Ces nouvelles informations vous ayant été communiquées, je vous prie de prendre connaissance de l'ébauche du rapport. Le sénateur Carstairs, le sénateur LeBreton et moi-même, qui sommes les trois membres de votre comité directeur, en avons pris connaissance plus tôt ce matin. Chacun peut maintenant poser des questions ou faire des observations.

Le sénateur Carstairs: J'ai bel et bien mentionné la préoccupation que voici au comité directeur, et c'est justement pourquoi j'ai tenu à en discuter avec le dernier groupe de témoins. Il est dit au dernier paragraphe:

Partageant leurs craintes, le comité demande instamment que le gouvernement fédéral modifie la Loi à la fin du premier mandat de cinq ans du président des IRSC [...]

Je tiens beaucoup à ce que l'on modifie le texte pour qu'il se lise ainsi: «envisage sérieusement d'amender le projet de loi». Nous avons entendu dire aujourd'hui qu'il pourrait en effet y avoir conflit dans la reddition de comptes au ministre de la Santé si l'on sépare le poste de président du conseil de celui de président.

Le président: Permettez-moi de vous répondre. Nous ne nous entendons pas sur cette question.

Bon nombre d'études qui ont été effectuées sur l'administration d'institutions de tout genre, à but lucratif, à but non lucratif, et d'institutions gouvernementales, ont fait valoir cet argument. Je dois dire que le comité des banques a étudié cette question sous tous les angles, qu'il s'agisse du conseil d'administration qui gère

some not-for-profit work we did. On the basis of the evidence we heard specifically on governance issues from a wide variety of groups, we came to the conclusion that the position of CEO and position of president/chair should be separated. We concluded that you should not have a position where the CEO is reporting to a board of which the CEO is also the chairman.

Despite what Dr. Worton said this morning, I would prefer to leave it the way it is. To be consistent with positions I have taken on a bunch of other issues, and I really believe it to be a trend of modern institutions, I would prefer to leave it the way it is. I am open to hear what the committee has to say.

Senator LeBreton: I support your position on this. It seems to me that it does not necessarily put the chairman or president positions in jeopardy. They really do, in most boards, have a different function, one reporting up and one reporting down.

The Chairman: Crown corporations are moving in that direction.

Senator LeBreton: If something should happen in the interim that would change our views, I suppose we could come back and address it. I support this position. Also, the workload is a consideration. If this body will work the way we hope it will work, it is matter of some efficiency to have two people.

Senator Robertson: Yes, I would support your position. I agree that there is just too much work to do, as well.

The Chairman: Any other comments on that issue or on the report.

Senator Callbeck: I agree with you.

Senator LeBreton: With respect to the question of "mental health", I felt strongly that we put that in.

The Chairman: We agreed to that after your comments.

Senator LeBreton: It was obvious from what the witness said last night that that is an area where we must get out from underneath that stigma.

The Chairman: I must write a note to Dr. Reading. In talking to my colleagues after the hearing last night, we all noted that his testimony last night was extremely impressive.

Senator LeBreton: We should also write to Mr. Upshall on the mental health side.

The Chairman: Yes. If there are no other comments, I would be happy to report this bill back to the Senate this afternoon, with the report attached that says that the bill be adopted without amendment but with the observations as attached.

Senator Carstairs: I so move.

The Chairman: Is it agreed?

Hon. Senators: Agreed.

le RPC, de sociétés privées, de sociétés à but non lucratif. Ayant entendu un grand nombre de groupes justement sur cette question de l'administration, nous en sommes venus à la conclusion que les postes de chef de la direction et celui de président du conseil d'administration doivent être séparés. Nous avons conclu qu'il ne faut pas se mettre dans une situation où le chef de la direction rend des comptes à un conseil d'administration dont il est également le président.

En dépit de ce qu'a dit le docteur Worton ce matin, je préfère laisser les choses telles quelles. Fidèle à la position que j'ai prise dans plusieurs autres dossiers, et je crois sincèrement que c'est aussi la tendance des institutions modernes, je préfère laisser les choses telles quelles. Cela dit, je suis disposé à entendre l'avis du comité.

Le sénateur LeBreton: Je suis d'accord avec vous. Il me semble que cela ne compromet pas nécessairement les postes de président ou de chef de la direction. Dans la plupart des conseils d'administration, ce sont des fonctions distinctes, l'une étant subordonnée à l'autre.

Le président: Les sociétés d'État évoluent en ce sens.

Le sénateur LeBreton: S'il se passe quelque chose dans l'intervalle qui modifierait nos vues, j'imagine que l'on pourra y voir. Je suis d'accord avec le président. Il y a aussi la question de la charge de travail. Si cet organisme doit travailler comme nous l'espérons, l'efficacité exige qu'il y ait deux personnes.

Le sénateur Robertson: Oui, je suis d'accord avec vous. Je suis d'accord également pour dire qu'il y a tout simplement beaucoup trop de travail à faire.

Le président: D'autres observations sur cette question ou le rapport?

Le sénateur Callbeck: Je suis d'accord avec vous.

Le sénateur LeBreton: Pour ce qui est de la question de la «santé mentale», je suggère fortement qu'on l'ajoute.

Le président: Nous nous sommes entendus là-dessus après vous avoir entendue.

Le sénateur LeBreton: D'après ce que les témoins nous ont dit hier soir, il est évident que c'est un domaine où il faut supprimer ce stigmate.

Le président: Je dois écrire un mot au docteur Reading. J'ai parlé à mes collègues après l'avoir entendu hier soir, et chacun a remarqué que son témoignage était extrêmement impressionnant.

Le sénateur LeBreton: Nous devons également écrire à M. Upshall au sujet de la santé mentale.

Le président: Oui. S'il n'y a pas d'autres observations, je serais heureux de faire rapport de ce projet de loi au Sénat cet après-midi et de présenter ce rapport qui dit que le projet de loi doit être adopté sans amendement mais avec les observations que nous annexons.

Le sénateur Carstairs: J'en fais la proposition.

Le président: D'accord?

Des voix: D'accord.

The Chairman: Then I shall report the bill this afternoon.

We will move on now to our second set of witnesses, which takes us back to our broad health care study, and we have with us Ms Colleen Fuller, for the Canadian Centre for Policy Alternatives, Mr. Robert Evans, University of British Columbia, and Mr. Martin Zelder, from the Fraser Institute.

Mr. Zelder, would you proceed, please.

Mr. Martin Zelder, Director of Health Policy Research, Fraser Institute: Before I begin my remarks, there is a mistake in my brief which I should correct.

In the last paragraph of the text, at the bottom of page 7 in the next to last line, it should say, "Despite abundant evidence that government enterprise is inefficient compared to private enterprise...". I apologize for any confusion this may have caused.

The main point of my brief, and of my comments today, is that medicare, while intended to embody generosity and compassion, especially for the poor, does not live up to these noble intentions. It does live up to these intentions because it is defectively designed.

The compassionate ideal, of course, was that medical care should be free at the point of use for all Canadians. That seemed like a good idea at the time, but we have learned a lot since then. What we — economists and public policy analysts — have learned, is that "free" does not necessarily imply "compassionate".

What does "free" imply? It implies long waits for many vital forms of care — much longer waits than in other comparable countries. The most recent finding: Canadians typically wait five months for a cranial MRI, whereas Americans wait only three days; and for a knee replacement, Canadians wait five and one half months, whereas Americans wait three and one half weeks.

Other studies find that Canadians wait longer than Swedes and Germans for urgent and elective cardiovascular surgery. The full details and references are on page 2 of my brief.

Canadian waiting is getting worse over time. Consider Table 1. Averaged across all specialities, waiting time has grown by 37 per cent — or 3.6 weeks — over the period from 1994 to 1998. During that same period, waiting time for chemotherapy grew by 44 per cent.

Why do Canadians wait so long? The long waits arise from two fundamental defects in the government's intervention in the medical system. These two defective elements are a badly designed insurance plan, and distorted incentives for spending health dollars in government-controlled hospitals.

The underlying problem with the insurance scheme is "moral hazard", or overuse. Economists first acquired a more precise understanding of moral hazard in the 1960s. The idea is that the

Le président: Je ferai donc rapport du projet de loi cet après-midi.

Nous allons entendre maintenant nos prochains témoins, ce qui nous ramène à notre étude générale sur les soins de santé, et nous recevons maintenant Mme Colleen Fuller, du Centre canadien de politiques alternatives, M. Robert Evans, de l'Université de la Colombie-Britannique, et M. Martin Zelder, de l'Institut Fraser.

Monsieur Zelder, nous vous écoutons.

M. Martin Zelder, directeur de la recherche sur les politiques de santé, Institut Fraser: Avant de commencer, je dois corriger une erreur qu'il y a dans mon mémoire.

Au dernier paragraphe de mon texte, au bas de la page 7, avant-dernière ligne, il faut lire: «En dépit des preuves abondantes qui démontrent que les entreprises gouvernementales sont inefficaces par comparaison aux entreprises privées...». Je vous prie de pardonner cette erreur.

Ce que mon mémoire dit essentiellement, et je le répéterai aujourd'hui, c'est que l'assurance-maladie, même si l'on veut qu'elle incarne la générosité et la compassion, particulièrement à l'égard des pauvres, n'a pas réalisé ses nobles intentions. Elle n'a pas réalisé ses intentions parce que sa conception est défectueuse.

Cet idéal humanitaire, bien sûr, consistait à offrir l'assurance-maladie gratuitement à tous les Canadiens, où qu'ils soient. L'idée semblait bonne à l'époque, mais nous avons appris beaucoup depuis. Ce que nous — économistes et analystes des politiques gouvernementales — avons appris, c'est que la «gratuité» n'est pas nécessairement «humanitaire». Que veut dire «gratuité»?

Cela veut dire de longues files d'attente pour plusieurs soins vitaux — des files qui sont beaucoup plus longues que dans d'autres pays comparables. Voici la constatation la plus récente: les Canadiens attendent normalement cinq mois pour un examen IRM crânien, alors que les Américains n'attendent que trois jours; et pour le remplacement d'un genou, les Canadiens attendent cinq mois et demi alors que les Américains n'attendent que trois semaines et demie.

D'autres études constatent que les Canadiens attendent plus longtemps que les Suédois et les Allemands pour une chirurgie cardio-vasculaire urgente ou élective. Vous trouverez les détails complets et les références à la page 2 de mon mémoire.

L'attente au Canada s'allonge de plus en plus. Voyez le graphique 1. Moyenne pour toutes les spécialités, où le temps d'attente a augmenté de 37 p. 100 — ou 3,6 semaines — de 1994 à 1998. Au cours de la même période, le temps d'attente pour la chimiothérapie a augmenté de 44 p. 100.

Pourquoi les Canadiens attendent-ils si longtemps? Ces longues attentes sont causées par deux déficiences fondamentales dans l'intervention gouvernementale au niveau du système médical. Ces deux éléments défectueux sont un régime d'assurance mal conçu et des incitatifs déformés dans la gestion des budgets des hôpitaux d'État.

La faiblesse fondamentale du régime d'assurance est le «danger moral» ou sa surutilisation. Les économistes ont commencé à mieux comprendre ce danger moral dans les années 60. Le fait est

existence of an insurance contract affects the insured individual's behaviour. More specifically, it means that an insured individual will use insured services to the point where the benefits to him or to her are far below their cost to society.

Because of the slow development of the theory of moral hazard, the founders of medicare did not realize how serious the problem might be. As leading medicare historian Malcolm Taylor describes the perspective at the time of Mackenzie King's thwarted 1945 plan:

No one really knew what a comprehensive public health insurance program would cost. ... there was no way of knowing what utilization would be if the total population were insured.

After the Saskatchewan hospital services plan of 1946 was in operation, "The costs of the plan... were considerably in excess of estimates", according to Taylor.

What the economists subsequently discovered was that co-insurance payments, or user fees, were a desirable and powerful mechanism to restrain moral hazard. However, even after this insight, and the warning signs noted by Taylor, medicare has persisted as an institution without user fees, for the most part.

Why has Canada not taken advantage of this growth in social-science knowledge? Perhaps it is because politicians have perennially attacked user fees. They have been emboldened by medicare's defenders in the academy, such as Professor Evans, who claims that user fees do not necessarily decrease "overall use" of medical services.

These claims have been thoroughly rebutted by one of the leading social-science research projects of the century, the RAND Health Insurance Experiment. The RAND researchers randomly assigned about 2,000 randomly-selected, non-elderly families to a variety of different insurance plans. The plans varied in terms of their user fee — 0 to 95 per cent of the bill — up to a maximum spending limit — 5, 10, or 15 per cent of family income, or U.S. \$1,000, whichever was smaller. The families were followed for three to five years in order to understand how assignment to different insurance groups affected health spending and health outcomes.

The RAND researchers found that those families who paid 25 per cent out of pocket, but never paid more than \$1,000 per year, incurred annual health care costs, on average, of U.S. \$826. By comparison, those in the "Canadian" group who paid nothing out of pocket, or 0 per cent co-insurance, incurred much higher annual costs of U.S. \$1013. This means that a 25 per cent co-insurance rate led to a reduction in annual spending of \$193 U.S., or a 19 per cent reduction.

The truly remarkable finding contained in the RAND analysis, however, relates to the change in health status among the families studied. Before-and-after comprehensive measures of health status permitted the RAND researchers to determine whether members

que l'existence de ce contrat d'assurance influence le comportement de l'assuré. Plus particulièrement, cela signifie que l'assuré va consommer les services au point où les avantages qu'il en retire sont de loin inférieurs à ce qu'il en coûte à la société.

Étant donné que la théorie du danger moral a été lente à émerger, les fondateurs de l'assurance-maladie n'ont pas saisi l'ampleur du problème. Le grand historien de la santé Malcolm Taylor décrit ainsi la perspective qu'on en avait à l'époque du plan avorté de Mackenzie King en 1945:

Personne ne savait combien coûterait un régime public d'assurance-maladie complet [...] Il n'y avait pas moyen de savoir quelle en serait l'utilisation si toute la population était assurée.

Après l'entrée en vigueur du régime des services hospitaliers de la Saskatchewan en 1946, «le coût du régime... dépassait de loin les estimations», selon Taylor.

Ce que les économistes ont découvert par après, c'est que les paiements complémentaires de l'assurance-maladie, ou tickets modérateurs, constituaient un mécanisme souhaitable et efficace qui permettait de limiter le danger moral. Cependant, même après qu'on a compris cela, même après qu'on a vu les avertissements relevés par Taylor, l'assurance-maladie est demeurée une institution sans tickets modérateurs, dans son ensemble.

Pourquoi le Canada n'a-t-il pas tiré parti de cette avancée du savoir social? C'est peut-être parce que les politiciens se sont toujours attaqués aux tickets modérateurs. Ils ont été enhardis par les défenseurs de l'assurance-maladie au sein de l'université, par exemple le professeur Evans, qui affirme que le ticket modérateur ne diminue pas nécessairement la «surconsommation» des services médicaux.

Ces affirmations ont été résolument réfutées par l'un des grands projets de recherche en sciences sociales du siècle, le RAND Health Insurance Experiment. Les chercheurs de la RAND ont assigné au hasard divers régimes d'assurance-maladie à environ 2 000 familles choisies au hasard et ne comprenant pas de personnes âgées. Les régimes variaient selon leur ticket modérateur — de 0 à 95 p. 100 de la facture — jusqu'à une limite maximale — 5, 10 ou 15 p. 100 du revenu familial, ou 1 000 \$US, le plus petit des deux montants étant retenu. On a suivi ces familles de trois à cinq ans pour comprendre comment l'assignation à divers régimes d'assurance-maladie influençait les dépenses en matière de santé et les conséquences pour la santé.

Les chercheurs de la RAND ont constaté que les familles qui payaient 25 p. 100 de leur poche, mais jamais plus de 1 000 \$ par année, avaient annuellement des dépenses de santé totalisant, en moyenne, 826 \$US. En comparaison, ceux du groupe «canadien» qui ne payaient rien de leur poche, ou 0 p. 100 de coassurance — présentaient des dépenses beaucoup plus élevées annuellement, soit 1 013 \$US. Ce qui veut dire qu'un taux de coassurance de 25 p. 100 menait à une réduction des dépenses annuelles de 193 \$US, soit une réduction de 19 p. 100.

La plus remarquable constatation découlant de l'analyse de la RAND, toutefois, concerne le changement de l'état de santé des familles examinées. Des mesures exhaustives de l'état de santé avant et après ont permis aux chercheurs de déterminer si les

of the "Canadian" plan, who received more health care, had better success in improving and maintaining their health than those who paid 25 per cent out of pocket or more. Extraordinarily, access to "free" health care did not benefit the "Canadians", with minor, albeit important, exceptions.

The exceptions — those whose health was benefited by the "Canadian plan" — were the "sick poor", those with low incomes, who, at the start of the experiment, had high blood pressure, vision problems, dental problems, or anaemia. However, "free" care had no beneficial health impacts outside of those "sick poor", who represented approximately 6 per cent of the population.

In fact, when other changes in government spending are taken into account, the Canadian poor may actually have been harmed by free care. In 1984, economists Lindsay and Zycher, who are cited in my references, found that, prior to established program financing in 1997, each additional dollar of government health spending crowded out 31 cents of social welfare spending. It is seriously debatable whether the small fraction of that dollar of health spending that went to the poor made up for the 31 cents of welfare spending they lost.

In the RAND experiment, for the other 94 per cent of the population, free care provided no health benefits. This means that much of the additional health services currently consumed due to the zero co-insurance "accessibility" of medicare are wasted. Thus, we should provide free care to the poor, without making them worse off by cutting other social programs, but redefine "accessibility" to mean a 25 per cent co-insurance rate, up to some modest expenditure limit, for the rest of the population.

The fact that there is extensive moral hazard within the current system is reflected in evidence regarding the connection between government health spending and waiting time. Specifically, I analyzed whether provinces in which more public money was spent per person on health care had shorter waiting times over the period 1992 to 1998. Controlling for other underlying factors that differed among the provinces, I found that there was no statistical relationship between public health spending per capita and waiting time. In other words, provinces that spent more government money per person had no shorter — and no longer — waiting times than provinces that spent less. The amount of money did not matter. This reveals moral hazard in that it reflects money being spent on valueless care, and preventing money being spent where it is valued, and thereby increasing waiting times for higher-valued care.

Further analysis that I did showed that the money that is being spent is not being spent in the right places.

membres du régime canadien, qui recevaient davantage de soins, avaient de meilleures chances de rester en bonne santé ou d'améliorer leur santé que ceux qui, de leur poche, versaient 25 p. 100 ou plus. Aussi incroyable que cela puisse paraître, l'accès à des soins de santé «gratuits» ne profitait pas aux Canadiens, sauf pour quelques exceptions secondaires mais néanmoins importantes.

Ces exceptions — soit ceux dont la santé s'était améliorée avec leur adhésion au régime canadien — sont les pauvres malades, les malades à faible revenu qui, au début de l'expérience, souffraient d'hypertension artérielle, de problèmes de vision, de problèmes dentaires ou d'anémie. Toutefois, les soins «gratuits» n'ont eu aucune incidence sur la santé des sujets autres que les malades pauvres qui représentaient environ 6 p. 100 de la population.

En fait, lorsqu'on tient compte d'autres changements en matière de dépenses gouvernementales, les Canadiens pauvres ont peut-être souffert de l'instauration des soins gratuits. En 1984, les économistes Lindsay et Zycher, que je cite dans mes références, ont constaté qu'avant l'instauration du financement des programmes établis en 1997, chaque dollar additionnel de dépenses gouvernementales en matière de santé entraînait l'élimination de 31c. en dépenses au chapitre de l'assistance sociale. Je doute fort que la très petite fraction de chaque dollar additionnel consacrée à la santé dont ont profité les pauvres ait compensé les 31 c. de dépenses en aide sociale qu'ils ont perdus.

Dans le cadre de l'expérience RAND, 94 p. 100 de la population n'a pas profité de la gratuité des soins de santé. Cela signifie qu'une bonne partie des services de santé additionnels qu'on consomme actuellement parce que les soins de santé sont accessibles, parce que le montant de la coassurance est de zéro, est gaspillée. Par conséquent, nous pourrions offrir des soins gratuits aux pauvres, sans leur nuire en comprimant les autres programmes sociaux, mais redéfinir aussi l'accessibilité de façon à prévoir une coassurance de 25 p. 100, jusqu'à une limite raisonnable, pour le reste de la population.

Le système actuel comporte un grand danger moral qui est manifeste dans les preuves sur le lien qui existe entre les dépenses gouvernementales en matière de santé et le temps d'attente. Plus précisément, j'ai tenté de déterminer si les provinces où l'on consacrait davantage, par personne, aux soins de santé avaient des temps d'attente moins longs pendant la période allant de 1992 à 1998. Ayant pris en compte les facteurs sous-jacents différents entre les provinces, j'ai constaté qu'il n'y avait aucun lien statistique entre les dépenses publiques par habitant en matière de santé et le temps d'attente. Autrement dit, dans les provinces où le gouvernement dépense davantage par habitant, le temps d'attente n'est ni plus court ni plus long que dans les provinces où on dépense moins. La somme d'argent importait peu. Cela témoigne d'un danger moral, puisque cela indique qu'on consacre de l'argent à des soins sans valeur, que cet argent pourrait être consacré à des soins plus utiles et que, par conséquent, le temps d'attente pour les soins utiles est d'autant plus long.

D'autres analyses m'ont permis de démontrer que les sommes consacrées aux soins de santé ne sont pas investis aux bons endroits.

Specifically, waiting times could be reduced if existing spending were reallocated into spending on drugs and on what is classified as "other professionals".

These findings illustrate the second substantial defect of medicare: the inefficiency of government enterprise. Although they are ostensibly private non-profit firms, Canadian hospitals are government controlled, both in terms of overall funding and in terms of resource allocation within hospitals. Consequently, it is not surprising that more spending does not reduce waiting, and that existing spending is misallocated.

As University of Rochester economist Eric Hanushek stated, in commenting about the fact that the vast majority of public education studies find no connection between spending and student performance in American public schools:

If few incentives exist to reward improved performance, it should not be surprising to find that resources are not systematically used in a fashion that improves performance.

In other words, resources will not tend to be allocated optimally in a system that does not reward optimal allocation. With regard to hospitals, of the 15 studies that compare the efficiency of for-profit and government hospitals, eight find that for-profits are lower-cost for a given level of quality, while only three find the reverse and four find no difference.

Ultimately, medicare has proven to be an object lesson in the economics of government failure. Despite abundant evidence that medical insurance should involve a modest co-insurance payment for the non-poor, medicare does not. Despite abundant evidence that government enterprise is inefficient compared to private enterprise, medicare relies on government enterprise. In the end, Duplessis, in his concern about Mackenzie King's proposal, was right: "Health insurance is dangerous." Medicare, designed and perpetuated without adequate social-scientific understanding, endangers Canadian compassion and Canadian lives. Economists were slow to understand insurance. Now that they do, it is time to cure medicare.

Ms Colleen Fuller, Research Associate, Canadian Centre for Policy Alternatives: Honourable senators, I will not review my submission, but rather I will focus on some of the initial steps that should be taken to resolve some of the tension that surrounds the health care system. That tension, from my perspective, is between for-profit medicine and universal entitlement. The tension goes back to the very beginnings of medicare and, in fact, to the beginning of the last century. There are historical roots to this tension that have never been resolved and have led to the current impasse, or crisis. I believe that the crisis in medicare possibly has

Plus précisément, on pourrait réduire le temps d'attente si les sommes existantes étaient réaffectées aux médicaments et aux soins dispensés par les «autres professionnels».

Ces constatations illustrent le deuxième important défaut de l'assurance-maladie: l'inefficacité de l'entreprise gouvernementale. Bien qu'ils soient des entreprises privées à but non lucratif, les hôpitaux canadiens sont sous contrôle gouvernemental, autant pour ce qui est du financement général qu'en ce qui a trait à l'affectation des ressources au sein de chaque hôpital. Conséquemment, il n'est pas étonnant que les dépenses accrues ne réduisent pas le temps d'attente et que les sommes actuelles ne soient pas bien affectées.

Voici ce qu'a déclaré l'économiste Eric Hanushek, de l'Université de Rochester, au sujet du fait que la majorité des études sur l'enseignement public ne révèle aucun lien entre les sommes dépensées et le rendement des élèves des écoles publiques américaines:

Si le rendement accru n'est pas récompensé, on ne devrait pas s'étonner de constater que les ressources ne sont pas systématiquement utilisées de façon à améliorer le rendement.

Autrement dit, dans un système qui ne récompense pas l'affectation optimale des ressources, ces ressources ne seront généralement pas affectées de façon optimale. Dans le cas des hôpitaux, dans les 15 études qui comparaient l'efficacité des hôpitaux privés et publics, huit études ont révélé que les coûts des hôpitaux privés étaient moindres pour un niveau de qualité donné, alors que trois seulement ont constaté le contraire et quatre, aucune différence.

En dernière analyse, l'assurance-maladie a été pour nous une leçon d'économie illustrant bien l'échec du gouvernement. En dépit des preuves abondantes selon lesquelles toute assurance médicale devrait comprendre une coassurance modeste pour tous sauf les pauvres, l'assurance-maladie ne prévoit pas une telle coassurance. En dépit des preuves abondantes selon lesquelles l'entreprise publique est inefficace comparée à l'entreprise privée, l'assurance-maladie compte sur l'entreprise publique. Duplessis avait raison de dire au sujet de la proposition de Mackenzie King: «L'assurance-maladie est dangereuse.» L'assurance-maladie, conçue et se perpétuant sans qu'on en comprenne bien les ramifications socio-scientifiques, met en danger la compassion et la vie des Canadiens. Les économistes ont mis du temps à comprendre l'assurance. Maintenant que c'est fait, le temps est venu de guérir l'assurance-maladie.

Mme Colleen Fuller, chercheuse associée, Centre canadien de politiques alternatives: Mesdames et messieurs les sénateurs, je ne lirai pas mon mémoire. Plutôt, je m'attarderai aux premières mesures qu'il faudrait prendre pour réduire la tension qui entoure le système de soins de santé. Pour ma part, j'estime que cette tension s'exerce entre la médecine à but lucratif et le droit universel à des soins de santé. Cette tension remonte aux tout débuts de l'assurance-maladie, en fait, au début du siècle dernier. Cette tension a des racines historiques dont on n'a jamais traité et qui ont mené à l'impasse ou à la crise actuelle. J'estime que la

to do with funding, but more probably has to do with the unresolved conflict in the health care system.

It would be helpful in resolving this conflict if the federal government were either to embrace medicare and defend the Canada Health Act, or to say, with all honesty, to the Canadian people that they no longer believe that all Canadians are entitled to health care services on uniform terms and conditions.

The conflict within the federal government is apparent right now: On the one hand there is the Health Minister, who appears to be completely immobilized when confronted with some of the events that are taking place in Ontario, in Alberta in particular, and in Quebec and other provinces, but who, as the Minister of Health, appears to be anxious in some ways, I suppose, or at least willing to address some of the problems that are occurring. On the other hand there is the federal government, which has reined him in. That situation reflects some of the internal conflict within the federal government.

The fundamental principle of the health care system is the principle of universal entitlement. The system was organized to support universal access — that was one of the very important principles when federal funds were released into the health system to support the construction of hospitals. Access was obviously an overriding concern. The laws that were passed to support medicare were primarily concerned with the principle of universal entitlement to a comprehensive range of services. That includes both the 1966 legislation and the Canada Health Act in 1984.

In 1984, which was a pivotal year in the health care system, the Canada Health Act was passed and, at the same time, there was a change in government that brought with it a change in the ideas of how the economy should be stimulated. It is fair to say that the Mulroney government was committed to an economy that was export-focused, or export-led, for economic growth. That is one of the reasons why they negotiated trade liberalization. Many of the objectives during that period clashed with the intent of the Canada Health Act and the goals that Canadians had for the health care system.

The underlying principle for the health care system, from about 1986 to the present day, has been that, to support the idea that health care goods and services should be exported, which is one of the things that Canada does well, there must be a health industry that can act as a platform into the global market. Thus, the principle is, "Domestic success precedes success abroad."

That also reflects the tension that I spoke about — the unresolved tension between health as a profitable industry and health as a public service. I believe that the two do not go hand-in-hand.

The unresolved tension has so immobilized the federal government that in 1984, then Minister of Health Monique Bégin circulated regulations to the provincial health ministers. There was much controversy over those regulations as the provinces did not agree with the Canada Health Act. They felt that it was an incursion into provincial jurisdiction. Eventually, a writ was

crise des soins de santé est peut-être liée au financement, mais qu'elle est plus probablement liée à un conflit non résolu qui perdure au sein du système de soins de santé.

Pour régler ce conflit, il serait bon que le gouvernement fédéral décide soit de défendre l'assurance-maladie et la Loi canadienne sur la santé, soit de dire honnêtement aux Canadiens qu'il ne croit plus que tous les Canadiens ont droit à des services de soins de santé aux mêmes conditions.

Le conflit qui fait rage au sein même du gouvernement fédéral est évident: d'une part, nous avons un ministre de la Santé qui semble tout à fait impuissant devant ce qui se passe en Ontario et en Alberta, surtout, ainsi qu'au Québec et dans les autres provinces, mais qui, comme ministre de la Santé, veut donner l'impression de vouloir, à tout le moins, corriger certains problèmes. D'autre part, nous avons le gouvernement fédéral qui lui tient la bride serrée. Cette situation témoigne du conflit interne qui existe au gouvernement fédéral.

Le principe fondamental du régime de soins de santé est l'universalité. Le système a été conçu de façon à appuyer l'accès universel — cela a été l'un des plus importants principes lorsque les fonds fédéraux ont été accordés pour la construction d'hôpitaux. L'accès était manifestement la préoccupation prépondérante. Les lois qui ont été adoptées à l'appui de l'assurance-maladie visaient surtout à mettre en pratique le droit universel à une gamme exhaustive de services. Cela comprend la Loi canadienne sur la santé de 1984 et la loi de 1966.

En 1984, année charnière pour le régime de soins de santé, la Loi canadienne sur la santé a été adoptée. Parallèlement, un nouveau gouvernement est arrivé au pouvoir avec des idées sur la façon de stimuler l'économie. Je crois pouvoir dire que le gouvernement Mulroney s'était engagé à assurer la croissance économique en faisant la promotion des exportations. C'est l'une des raisons qui l'ont poussé à négocier la libéralisation des échanges commerciaux. Bon nombre des objectifs de ce gouvernement allaient à l'encontre de l'intention de la Loi canadienne sur la santé et des objectifs canadiens au chapitre du régime de soins de santé.

De 1986 à nos jours, le système de soins de santé a reposé sur le principe selon lequel, pour favoriser l'exportation des biens et services de santé, un des atouts du Canada, on doit disposer d'une industrie de la santé qui serve de tremplin vers le marché mondial. On pourrait résumer ainsi ce principe: «Le succès au pays précède le succès à l'étranger.»

Cela reflète la tension dont j'ai parlé il y a un moment: la tension toujours présente entre la santé comme industrie rentable et la santé comme service public. À mon avis, ces deux visions sont inconciliables.

Cette tension toujours présente a paralysé le gouvernement fédéral au point où, en 1984, la ministre de la Santé de l'époque, Monique Bégin, a fait parvenir un règlement aux ministres provinciaux de la Santé. Ce règlement a été très controversé, car les provinces n'appuyaient pas la Loi canadienne sur la santé, estimant qu'elle représentait une ingérence dans un champ de

dropped before the regulations were passed and attached to the legislation.

Consequently, there were no regulations until 1986, when the Conservatives introduced the “extra billing” and “user fee” information regulation. That is currently the only regulation attached to the Canada Health Act.

As this tension exists within the federal government, there also exists indecision about the direction that they will pursue in respect of health care. Thus, we have the current situation and nobody knows how to interpret the act — what are the criteria of the act? We do not have any guidance, except what occurred during the original debates in the House of Commons, surrounding the introduction of the legislation, because there are no regulations.

In addition to the federal government’s clarifying its own position on medicare, we need to develop regulations to clarify the intent of the act, which is the national framework for our health care system. Those regulations must be developed in full public view and with public participation.

Back in the early 1990s, there were conflicts between Health Canada and several provinces, including both my province of British Columbia and Alberta, over the issue of extra billing and user fees, or “facility fees” as they were called then. Diane Marleau, when she became the health minister in the new Liberal government, also inherited a piece of legislation with no regulations and no clarified intent. She tried to confront some of the provinces that were introducing facility fees.

Some of those facility fees, by the way, were not simply deterrent fees. In Alberta, the fee for cataract surgery was \$1,275. I suppose you could call that a deterrent fee, because, if you could not afford it, you certainly would be deterred from getting cataract surgery.

Marleau confronted Alberta over the issue of facility fees; however, there was no help in the legislation to deal with such a thing as facility fees. So Marleau issued a letter, a formal ruling I suppose you would call it, to her provincial counterparts on the issue of facility fees. She said that facility fees or user fees applied to hospital services were a violation of the act, and that those services — acute care, chronic care and rehabilitation — were covered by the criteria of the act, regardless of venue.

From my perspective, “regardless of venue” was the most important thing that she said in that ruling. “Regardless of venue” means that those hospital services being delivered in the eye clinics or in the health resource group hospital, or wherever, are covered by the criteria of the act. That means no user fees, no extra billing, no means-testing, nothing. Everything is supplied as part of the public health insurance plan.

Marleau was the first and last minister to clarify the intent of the act. To this day, no one has overturned her ruling, but she did not get the support of the federal government that she required in order to push forward that interpretation and ruling. In fact, her

compétence provincial. Pour finir, un bref a été déposé avant que le règlement ne soit adopté et annexé à la loi.

Par conséquent, la loi est restée sans règlement jusqu’en 1986, année où les conservateurs ont fait adopter le règlement sur les informations concernant la surfacturation et le ticket modérateur, qui reste le seul règlement joint à la Loi canadienne sur la santé.

Pendant que cette tension perdure au sein du gouvernement fédéral, celui-ci devient de plus en plus indécis sur l’orientation qu’il devrait adopter en matière de soins de santé. Ainsi, nous nous retrouvons dans la situation actuelle et personne ne sait comment interpréter la loi: quels sont les critères prévus par la loi? Rien ne nous guide, sauf le débat tenu par les députés à la Chambre des communes au moment du dépôt du projet de loi, puisqu’il n’y a pas de règlements.

Outre une position claire du gouvernement fédéral en matière d’assurance-maladie, il nous faut une réglementation qui précise l’intention de la loi, laquelle constitue le cadre national de notre régime de soins de santé. Cette réglementation doit être élaborée en public et avec la participation de la population.

Au début des années 90, il y a eu des différends entre Santé Canada et plusieurs provinces, y compris ma province de la Colombie-Britannique et l’Alberta, au sujet de la surfacturation et du ticket modérateur, ce qu’on appelait à l’époque les frais d’établissement. Diane Marleau, lorsqu’elle est devenue ministre de la Santé du nouveau gouvernement libéral, a hérité d’une mesure législative sans règlements ni intention claire. Elle a tenté de faire face à certaines des provinces qui voulaient instaurer des frais d’établissement.

Certains de ces frais d’établissement, soit dit en passant, ne relevaient pas du ticket modérateur. En Alberta, les frais demandés pour une chirurgie de la cataracte étaient de 1 275 \$. D’une certaine façon, c’est un ticket modérateur, car si vous n’avez pas les moyens de payer ces frais, cela modérera votre souhait de subir une chirurgie de la cataracte.

Mme Marleau s’est opposée à l’Alberta au sujet des frais d’établissement; toutefois, rien dans la loi ne traitait de ces frais. Elle a donc fait parvenir une lettre, qui représentait, je suppose, une décision officielle, à ses homologues provinciaux sur la question des frais d’établissement. Elle y stipulait que les frais d’établissement ou ticket modérateur s’appliquant aux services hospitaliers violaient la loi et que ces services — soins actifs, soins chroniques et réadaptation — tombaient sous le coup de la loi et de ses critères, peu importe l’endroit.

Pour ma part, j’estime que ces derniers mots, «peu importe l’endroit», étaient les plus importants. Ils signifient que la loi s’appliquait aux services hospitaliers dispensés dans les cliniques ophtalmologiques, les hôpitaux privés, ou ailleurs. Cela signifiait qu’ils ne pouvaient faire l’objet d’un ticket modérateur, de surfacturation ou de frais établis en fonction des ressources. Tous ces services devaient être dispensés dans le cadre du régime public d’assurance-maladie.

Mme Marleau a été la première et la dernière ministre à préciser l’intention de la loi. Jusqu’à présent, personne n’a contredit sa décision, mais elle n’a pas joui de l’appui du gouvernement fédéral qu’il lui fallait pour promouvoir cette

successor, David Dingwall, in his 1996 report to Parliament, contradicted her position. He said that, because of health care reform, all these services are going into the community and, unfortunately, once they are outside the hospital, they are no longer covered by the criteria of the act. It was not as formal a position as Marleau had taken, but it contradicted her position.

Marleau's position and her ruling have not been, to this day, formally embraced by the federal government. In my opinion, Marleau's ruling should be upheld by the federal government since it is the only ruling that has ever come out of Health Canada on the criteria for the application of the act. It would certainly clarify some of the outstanding issues that we are confronting now around things like Bill C-13.

I also think it would be helpful — in fact, I think it is necessary — to begin considering removing health care from the Canada Health and Social Transfer. I say this for a number of different reasons. First, the federal government has no idea how those cash transfers are being spent. They could be spent on post-secondary education, on health care or social assistance, being the three areas within the CHST portfolio. Most likely, they are spending it on health care but at the expense of other very important programs. For that reason, I think that health should be removed.

The second reason is something that happened when the CHST was introduced. There were nine amendments to the Canada Health Act as a consequence of the CHST. Most of them were minor amendments, changing references to EPF funding and cash transfers. The one important amendment was the repeal of section 6 of the act. Section 6 was the only part of the Canada Health Act that obliged the government to dedicate funding to what were termed "extended health services." Extended health is now the fastest growing part of the health system. It includes home care, nursing home care and ambulatory care. Basically that covers home care, community and long-term care.

The repeal of that section from the Canada Health Act has removed the government from that area, in spite of the rhetoric that comes from the federal government about home care and a national home care program and so on. The government has actually cut their legs from underneath them by repealing that section of the act. If they had not done that but had upheld Marleau's original ruling, we would not need to talk about a separate home care and community care act.

Finally — and I know this is extremely controversial, but I will say it anyway — we need to consider a constitutional amendment to divide jurisdiction in health care between the provinces and the federal government. I know the provinces would squeal about that, but the provinces have done nothing but squeal about the federal government's involvement. The Constitution has not been clear about jurisdiction in health care.

interprétation de la loi. En fait, son successeur, David Dingwall, dans son rapport de 1996 au Parlement, a contredit la position de Mme Marleau. Il a déclaré que, en raison de la réforme des soins de santé, tous ces services seraient dispensés dans la collectivité et que, malheureusement, s'ils n'étaient pas dispensés dans un hôpital, la loi ne s'appliquait plus. Ce n'était pas là une position officielle comme celle qu'avait adoptée Mme Marleau, mais elle contredisait sa position à elle.

Jusqu'à ce jour, le gouvernement fédéral a refusé de faire sien la position de Mme Marleau. À mon avis, la décision de Mme Marleau devrait être confirmée par le gouvernement fédéral puisque c'est la seule décision qu'ait jamais rendue Santé Canada sur les critères d'application de la loi. Cela éclaircirait sans doute certaines des questions encore sans réponse qui ont été soulevées notamment en rapport avec le projet de loi C-13.

Il serait aussi utile — en fait, j'estime que c'est nécessaire — d'envisager le retrait des soins de santé du Transfert canadien en matière de santé et de programmes sociaux, et ce, pour plusieurs raisons. Premièrement, le gouvernement fédéral n'a pas la moindre idée de ce à quoi servent ces transferts de fonds. Ils peuvent très bien servir à l'enseignement postsecondaire, aux soins de santé ou à l'aide sociale, les trois domaines du TCSPS. Il est fort probable que les provinces consacrent cet argent aux soins de santé, mais au détriment d'autres programmes très importants. Voilà pourquoi, entre autres raisons, la santé devrait être retirée du TCSPS.

Deuxièmement, il s'est produit une chose lorsque le TCSPS a été instauré: neuf modifications ont été apportées à la Loi canadienne sur la santé. Certaines étaient de peu d'importance et ne faisaient que modifier les mentions du financement des programmes établis et des transferts de fonds. On a toutefois apporté une modification importante: l'abrogation de l'article 6 de la loi. L'article 6 était la seule disposition de la Loi canadienne sur la santé qui obligeait le gouvernement à consacrer des fonds à ce qu'on appelait les «services complémentaires de santé». Les services complémentaires de santé sont ceux qui connaissent la croissance la plus rapide à l'heure actuelle. Ils comprennent les soins à domicile, les soins infirmiers à domicile et les soins ambulatoires. Il s'agit essentiellement de soins à domicile, de soins communautaires et de soins de longue durée.

L'abrogation de cet article de la Loi canadienne sur la santé a marqué le retrait du gouvernement fédéral de ce domaine, en dépit des belles promesses de ce gouvernement au sujet des soins à domicile, d'un programme national de soins à domicile, et ainsi de suite. En fait, le gouvernement s'est tiré dans le pied en abrogeant cet article de la loi. S'il avait plutôt maintenu la décision originale de Mme Marleau, nous n'aurions pas à envisager une loi distincte sur les soins à domicile et les soins communautaires.

Enfin — et je sais que c'est très controversé, mais je le dis néanmoins — il faut envisager une modification constitutionnelle qui ferait des soins de santé une compétence partagée entre les provinces et le gouvernement fédéral. Je sais que les provinces jetteront les hauts cris, mais les provinces se sont toujours plaintes de la participation du gouvernement fédéral dans ce champ de compétence. La Constitution n'a jamais établi clairement la compétence en matière de soins de santé.

This question was addressed in 1948 by the Rowell-Sirois commission. They recommended that the jurisdiction be left undefined so that there could be a potential for cooperation between the provinces and the federal government. That was wishful thinking. It has never come about. We need to consider shared jurisdiction and shared funding and conditional funding to the provinces, with 50-50 jurisdiction and 50-50 funding.

If that happened, some of the other problems we are confronting now would be more easily addressed. I am not saying they would be solved, but they would be more easily addressed.

Mr. Robert G. Evans, Director, Population Health Program, University of British Columbia: Mr. Chairman, I will not quote Maurice Duplessis or try to enter into a constitutional discussion. That is not where I want to go.

The phrase that came to mind as I was thinking about these issues goes back to Sir Isaiah Berlin who distinguished two different styles of intellectual approach or ways of understanding the world under the phrase, "the fox and the hedgehog." The fox knows many things and the hedgehog knows one big thing.

In dealing with this set of issues, we might want to think about the approach of the hedgehog in looking at the fundamental principles and structure of our system. We know "one big thing" surrounding the effects and the success of a universally funded system.

When we come to think about how the system must be improved and adapted to changing circumstances, then we are in the position of the fox. There is no magic bullet. Actually bullets tend to kill people, rather than make them healthier. There is no dramatic stroke that we can take to somehow change the system for the better. We probably could change it for the worse, as with bullets. There are a number of things that, if we are clever enough, we can do to make the system work a lot better.

I ran across a paper by Professor Contandriopoulos of the University of Montreal that has just arrived in Volume 1, No. 1, of the *Canadian Journal of Policy Research*, which has just come out from under embargo. His paper on the situation of the Canadian health care system draws an important framing distinction. He says that we are in circumstances in which, like every other health care system in the developed world, we are engaged in trying to think through reform to deal with a crisis. These problems are universal. Any structure, any approach, that treats medicare in isolation from the rest of the world is almost certainly misleading.

On the other hand, while we share the common problem of adaptation and reform, we are in a peculiar circumstance in that we do not live on the shores of the Baltic; we live next to the United States. The journal volume which I referenced is dedicated

En 1948, la commission Rowell-Sirois a traité de cette question. Elle a recommandé que ce champ de compétence ne soit pas défini afin que restent intactes les possibilités de collaboration entre les provinces et le gouvernement fédéral. C'était un vœu pieux qui ne s'est jamais réalisé. Il faut envisager un partage de cette compétence, un partage du financement et un financement conditionnel pour les provinces, autrement dit, un partage égal des responsabilités dans ce champ de compétence ainsi que du financement.

Ainsi, certains des problèmes auxquels nous faisons actuellement face seraient plus faciles à régler. Je ne prétends pas que ce serait la solution miracle, mais il serait plus facile de régler ces problèmes.

M. Robert G. Evans, directeur, Programme de santé des populations, Université de la Colombie-Britannique: Monsieur le président, je ne citerai pas Maurice Duplessis et ne tenterai pas non plus de m'engager dans une discussion constitutionnelle. Cela ne m'intéresse pas.

En réfléchissant à toutes ces questions, j'ai pensé à sir Isaiah Berlin, qui faisait la distinction entre deux façons différentes d'aborder intellectuellement ou d'envisager le monde en parlant du renard et du hérisson. Le renard sait bien des choses, le hérisson, lui, ne sait qu'une seule grande chose.

Pour traiter de toutes ces questions, nous adoptons l'approche du hérisson quand nous examinons les principes fondamentaux et la structure du système. Nous savons «une seule grande chose» sur les effets et le succès de tout régime à financement universel.

Lorsque nous nous demandons comment améliorer le système et l'adapter aux circonstances changeantes, nous adoptons l'approche du renard. Il n'y a pas de projectile magique. En fait, les projectiles servent habituellement à tuer les gens plutôt qu'à les guérir. Il n'y a pas de mesures radicales que nous puissions prendre pour améliorer le système du jour au lendemain. En fait, les changements que nous apporterions ainsi ne feraient probablement qu'empirer les choses, comme les projectiles. Toutefois, si nous sommes assez astucieux, nous pouvons faire certaines choses pour veiller à ce que le système fonctionne bien mieux.

Je suis tombé sur un article de M. Contandriopoulos, professeur à l'Université de Montréal, et paru dans le numéro 1 du volume 1 du *Canadian Journal of Policy Research* et dont la publication vient d'être autorisée. Son article sur la situation du régime de soins de santé canadien fait une distinction importante sur la compréhension du système. Il affirme que notre situation est telle que, comme tous les autres pays du monde industrialisés, nous tentons de régler la crise de notre système de soins de santé grâce à des réformes. Ces problèmes sont universels. Toute structure, toute approche qui envisage l'assurance-maladie isolément du reste du monde nous fera certainement faire fausse route.

En revanche, bien que nous ayons en commun avec les autres pays industrialisés le problème d'adaptation et de réforme, nous sommes dans une situation bien particulière, en ce sens que nous ne sommes pas sur les rives de la mer Baltique, mais bien juste à

to all the issues and problems surrounding continental integration. Contandriopoulos raises the question: Is it possible to have, in an integrated North American environment, two systems for health care based on totally different principles? He draws from that the notion that, yes, it may continue to be possible, but it will require continuous political management and will. If you simply let things slide, if you approach the problems with an attitude of benign neglect, and one sometimes has the feeling that our governments have done that, then the natural forces take you in the direction of an American style system.

That system last year was described by the editor of the *New England Journal of Medicine*, in introducing a series of articles on the American system, as at the "most costly," by a very long margin, the "most inefficient," by a substantial margin, and the "least equitable" system in the developed world. That is the direction in which natural market forces and natural integration will take us, unless we are continually prepared to deal with our system consciously, actively and thoughtfully.

Furthermore, not only is the American-style approach all of the things described in that *New England Journal of Medicine* editorial, but at the moment it also seems to be rather helpless and hopeless, judging from articles coming out in the *New York Times*. Managed care seems to be failing, and they have nowhere else to go.

Canadians are in this peculiar environment in which we must continuously maintain the existence of the system, as we must the existence of the country of Canada itself, by acts of will. We cannot rely on natural forces to do it for us. That is a fundamental perspective that Professor Contandriopoulos lays out in a particular way.

If we accept that, what then? Do we not have a crisis? If 80 per cent of the people in the country think we have a crisis, then we have a crisis. There is no doubt about that. Whether the crisis is what they think it is or not is another set of more complex questions, but there is a problem here.

We might approach it in the spirit in which a physician might approach a patient's crisis. Providing we are not in the emergency ward and bleeding to death — and we are not, despite the rhetoric — the physician would take a history, do some tests, gather some data, and try to formulate a diagnosis. When that was done, the physician would think through an approach to therapy with perhaps several different therapies in mind, but the structure of history-diagnosis-therapy seems to be a rather good one.

Is that what is going on now? No, it is not. We have people rushing forward energetically and loudly proposing therapies. Then they work back to look for a diagnosis that will be consistent with the therapy they have recommended, so they make that up. "Forget about history and tests. We are in a crisis and we are busy here."

This is the pattern of behaviour, which I think all of you will be able to see around you. This pattern comes from the fact that, rather than having a common objective — I have used elsewhere the notion of the death of a steersman — and trying to find out

côté des États-Unis. Le volume du périodique dont je viens de faire mention est consacré à tous les enjeux et problèmes entourant l'intégration continentale. Contandriopoulos soulève la question suivante: Dans un environnement nord-américain intégré, peut-il y avoir deux systèmes de santé fondés sur des principes totalement différents? Il conclut que, oui, cela peut être possible, mais cela nécessitera une gestion et une volonté politiques continues. Si vous laissez les choses aller, si vous faites face aux problèmes en adoptant une attitude d'aimable indifférence, et c'est l'impression que donnent parfois nos gouvernements, les forces naturelles entraîneront l'américanisation de notre système.

L'an dernier, le rédacteur en chef du *New England Journal of Medicine*, dans sa présentation d'une série d'articles sur le système américain, l'a décrit comme étant de loin le plus coûteux, le plus inefficace et le moins équitable des régimes du monde industrialisé. Les forces naturelles du marché et de l'intégration nous mèneront sur cette voie, à moins que nous ne soyons constamment prêts à prendre soin de notre système de façon consciente, active et réfléchie.

L'approche américaine est tout à fait comme l'a décrite l'éditorial du *New England Journal of Medicine*, et, en outre, il semble que la situation soit sans espoir, si on en juge d'après les articles qui paraissent dans le *New York Times*. Les soins gérés semblent empirer et les gens n'ont nulle part où aller.

Nous, les Canadiens, sommes donc dans une situation particulière: nous devons continuellement maintenir l'existence du système, comme l'existence du pays même, grâce à des actes de volonté. Nous ne pouvons compter sur les forces naturelles pour ce faire. C'est essentiellement le point de vue de M. Contandriopoulos.

Si nous abondons dans le même sens, que faire? Ne faisons-nous pas face à une crise? Si 80 p. 100 des Canadiens estiment qu'il y a une crise, c'est qu'il y a une crise. Ça ne fait aucun doute. Que la crise soit celle qu'ils croient ou non soulève d'autres questions complexes, mais il y a néanmoins un problème.

Nous pourrions aborder la question comme un médecin aborde tout patient en état de crise. Si je ne suis pas à l'urgence, sur le point de mourir au bout de mon sang — et ce n'est pas le cas du système de soins de santé canadien, en dépit de tous les discours — le médecin prendrait note de mes antécédents, me ferait passer quelques tests, rassemblerait des données et tenterait de formuler un diagnostic. Après quoi le médecin élaborerait un traitement à partir de plusieurs thérapies différentes, toujours selon le modèle antécédents diagnostic-thérapie.

Est-ce ce qui se fait à l'heure actuelle? Non. Les gens se précipitent et proposent énergiquement toutes sortes de solutions. Puis, ils tentent d'établir un diagnostic qui serait conforme à la solution qu'ils ont recommandée et finissent par en inventer un. Ils font fi des antécédents et des tests. Ils affirment que nous sommes en crise et qu'il faut agir.

C'est ainsi qu'on a tendance à se comporter, et vous avez tous pu le constater. Cette tendance découle du fait que, plutôt que de donner un objectif commun — j'ai déjà employé ailleurs la métaphore de la mort du barreur — et de tenter de trouver

how best to get to that objective, we are instead in a world with multiple agendas with very different purposes being hooked on to our health care systems.

Forty years later, heaven forbid, we are back here talking about user charges again. Those recommendations come out of separate agendas that are not connected with what might be a broad, loose, ill-defined, overall objective of efficiently providing effective and equitable care. We actually do believe in such care and we do try to achieve it, but private objectives are driving many of the recommendations for changes in the system.

I would link those private agenda objectives under three heads. I think you can hold onto them in your minds quite quickly — and I do apologize for not having comprehensive notes. The three heads are: “Who pays?”; “Who gets?”; and “Who gets paid?”

“Who pays?” has to do with tax finance versus private insurance versus user pay. The more you use tax finance, the more you take the money from the healthy and wealthy, because the wealthy pay more taxes, in general, and the healthy do not use as much health care. The more you rely on private finance, the more you take the money from the unhealthy and the unwealthy. Therefore, there will be a continuing contest between the healthy and wealthy on the one side and the unhealthy and unwealthy on the other side over the most appropriate form of financing.

This is in no way peculiar to Canada. There is no extensive evidence from the European Community or the United States. It is a political judgment. The distribution of the burden — “Who pays?” — will be heavily dependent on the particular sources of financing.

The “Who pays?” question is critical to the sources of finance. The issue of taxation versus private finance is an issue of whether you want the heavier burden to lie at the lower or the upper end of the income distribution. Some very interesting work on that has come out of the University of Manitoba, and I have some coloured charts if anyone wants to look at them.

“Who gets?” is related to that. Do you get access based on your ability to pay or on your adjudged need. The answer is never exactly one or the other, but the more heavily you rely upon, say, a two-tier system with a user-pay component, the more you will find that the ability to pay is driving access. There are no mysteries about this. Economics is not really a science, but sometimes you can maintain a firm grasp on the obvious. The “Who gets?” is the question that is driving the arguments over a two-tier system in this country.

Then “Who gets paid?” has to do with both the kinds of people and the kinds of organizations that can get access to the market. Is there a space for private insurance, for example, or not? If so, then how much do they get paid? Again, the arguments over extra billing, double billing, facility fees, and so on, all arise out of efforts by care providers to get around the semi-effective

comment nous pourrions le mieux atteindre cet objectif, nous laissons toutes sortes de gens qui ont des buts bien différents s'occuper de notre système de soins de santé.

Quarante ans plus tard, le ciel nous en préserve, nous reparlons de tickets modérateurs. Ces recommandations découlent de plans d'action distincts qui ne sont même pas interreliés par ce qui pourrait être un objectif général bien que mal défini, soit de dispenser de façon efficiente des soins efficaces et équitables. Ce sont là les soins que nous voulons offrir et que nous tentons d'offrir, mais des objectifs privés suscitent bon nombre des recommandations de modifications du système.

Je classerais ces objectifs privés sous trois grandes rubriques. Je crois que vous pourrez les garder à l'esprit facilement — et je m'excuse de n'avoir pas un mémoire exhaustif pour vous. Ces trois rubriques sont les suivantes: «Qui paie?», «Qui reçoit?» et «Qui est payé?»

La rubrique «Qui paie?» comprend le financement par l'impôt, l'assurance privée et le ticket modérateur. Plus vous avez recours au financement par l'impôt, plus vous vous servez de l'argent des riches et de ceux qui sont en bonne santé, parce que les riches versent habituellement davantage d'impôt et les personnes en bonne santé reçoivent peu de soins de santé. Plus vous comptez sur le financement privé, plus vous prenez votre argent chez les pauvres et les malades. Par conséquent, il y aura toujours concurrence entre les personnes riches et en bonne santé, d'une part et les personnes pauvres et malades, d'autre part, en ce qui a trait à la meilleure formule de financement.

Ce n'est pas caractéristique du Canada. Nous n'avons pas de données exhaustives sur ce qui se fait à la Communauté européenne ou aux États-Unis. C'est un jugement politique. La répartition du fardeau — «Qui paie?» — dépendra en grande partie des différentes sources de financement.

La question de savoir qui paie est cruciale pour les sources de financement. Pour savoir si on privilégiera le financement par l'impôt ou le financement privé, il faut se demander si on veut que ce soit les plus riches ou les plus pauvres qui assument la plus grande part du fardeau. Des études très intéressantes ont été faites à ce sujet à l'Université du Manitoba et j'ai des tableaux en couleur si ça vous intéresse.

La rubrique «Qui reçoit?» est liée à la première. A-t-on accès aux soins de santé en fonction de sa capacité de payer ou en fonction de ses besoins? La réponse n'est jamais catégoriquement l'une ou l'autre, mais si le système est à deux niveaux et qu'il prévoit un ticket modérateur, l'accès est tributaire de la capacité de payer, cela n'a rien de mystérieux. L'économie n'est pas véritablement une science, mais certaines évidences sont faciles à comprendre. C'est la question de savoir qui reçoit les soins de santé et qui est à la base du débat sur le système à deux niveaux au pays.

Lorsqu'on se demande «Qui est payé?», on se demande quels genres de gens et d'organisations peuvent avoir accès au marché. Y a-t-il de la place pour l'assurance privée, par exemple, ou non? Dans l'affirmative, combien ces entreprises recevront-elles? Encore une fois, les discussions concernant la surfacturation, la double facturation, les frais d'établissement, et cetera, découlent

bargaining over the costs, which you get from provincial governments but which private systems are incapable of providing.

The notion that you require a public, political and governmental will to mobilize a general view of what we want in our health care system — and that general will is out there, as we all know — and to mobilize that against the fragmenting forces of “Who pays?”, “Who gets?”, “Who gets paid?” is what makes the role of government essential in this whole thing.

That points to why, as Colleen Fuller says, a policy of benign neglect leads to continuing deterioration.

To go back to the history again, throughout the history of medicare, and even before, there has been continuous rhetoric, political theatre, about the crisis in the system. *The Financial Post* invited me to its first “Crisis on Medicare Forum” in 1974. They held them every couple of years after that until people got bored with that title; then they started to find something else.

The combination of rhetoric of “crisis” with rhetoric of “cost explosions” is as old as our program. The debates over whether more private funding would have some effect, positive or negative, are at least that old. You must understand the important role played by this rhetoric in debates over resource allocation and relative incomes from the beginning of the plan. You do not want to take it at face value.

On the other hand, while the presence of “crisis” rhetoric and “over-funding” rhetoric and “over-cost-explosion” rhetoric does not necessarily mean that those things are going on, it does not mean that they are not, either. That is sort of the standard noise pattern of the system. What really has been going on, throughout the history of medicare and contrasting with the previous decades, is that the system has actually been fairly well controlled. Costs have not exploded, for example, the way they have in the United States, where the principles that Mr. Zelder has so ably articulated have been taken into heart in constructing their system and have produced the most costly, most inefficient system, as I described.

Our system embodied a great deal of inefficiency — there is no question about that — and stayed within reasonable cost bounds until the collapse of our economy in the 1980s. It has been the fiscal pressures that have triggered the crisis, rather than the system itself.

A spokesman for the CMA once said, “There is nothing wrong with the Canadian health care system, but we really do need to get a new economy.” That was factually correct but somewhat impractical to put into practice. We have been wrestling, for the last ten years, with how to adapt a health care system that is rather stubborn about funding matters to live within a more constrained economy. Despite all the rhetoric of boom, we are not actually doing better in economic growth terms than we were prior to 1980. This just a situation that fosters the expression: “We have been down so long it looks like up to me.” Things look good in

toutes des efforts des dispensateurs de soins de santé en vue de contourner les négociations à moitié efficaces sur les coûts qui sont le propre des gouvernements provinciaux, mais dont sont incapables les systèmes privés.

Le rôle du gouvernement est essentiel dans tout cela, car il faut une volonté publique, politique et gouvernementale pour mobiliser la population et en venir à une vision d'ensemble de ce que nous voulons de notre système de soins de santé — cette volonté existe, nous le savons — et de se mobiliser contre les forces qui mènent à la fragmentation, «Qui paie?», «Qui reçoit?», «Qui est payé?»

Ce qui indique pourquoi, comme le dit Colleen Fuller, une politique d'aimable indifférence aboutit à une détérioration permanente.

Pour revenir à l'histoire, tout au long de l'histoire de l'assurance-maladie, et même auparavant, on n'a cessé sur le plan politique de parler et de poser pour la galerie s'agissant de la crise que traversait le système. En 1974, le *Financial Post* m'a invité à sa première tribune sur la crise de l'assurance-maladie. Il en a tenu à intervalles réguliers jusqu'à ce que les gens se lassent de ce thème; il a alors essayé de trouver autre chose.

Cette rhétorique de «crise» conjuguée à cette rhétorique d'«explosion des coûts» existe depuis aussi longtemps que notre programme, tout comme les débats sur les conséquences, positives ou négatives, de l'augmentation du financement privé. Il faut comprendre le rôle important joué par cette rhétorique dans les débats sur l'attribution des ressources et les revenus relatifs depuis le début du régime. Il ne faut pas la prendre au pied de la lettre.

Par contre, bien que l'existence de cette rhétorique de «crise», de «surfinancement» et d'«explosion des coûts» ne reflète pas forcément la réalité, cela ne signifie pas qu'elle ne contient pas une part de vérité. C'est un peu le bruit de fond du système si on peut dire. La réalité, tout au long de l'histoire de l'assurance-maladie et par contraste avec les décennies précédentes, c'est que le système a en fait été assez bien contrôlé. Les coûts n'ont pas explosé par exemple comme cela a été le cas aux États-Unis, où les principes énoncés par M. Zelder de façon si compétente ont été pris à coeur dans l'établissement de leur système et ont produit le système le plus coûteux et le plus inefficace, tel que je l'ai décrit.

Notre système comportait une bonne part d'inefficacité — cela ne fait aucun doute — et a maintenu des coûts raisonnables jusqu'à l'effondrement de notre économie dans les années 80. Ce sont les pressions financières qui ont déclenché la crise, plutôt que le système même.

Comme l'a déjà dit un porte-parole de l'AMC, «le régime de soins de santé du Canada fonctionne bien, mais c'est d'une nouvelle économie dont nous avons vraiment besoin.» Cette déclaration était correcte dans les faits mais plutôt difficile à mettre en pratique. Depuis les 10 dernières années, nous essayons d'adapter un régime de soins de santé plutôt rigide en matière de financement en fonction d'une économie plus restreinte. Malgré toute la rhétorique du boum économique, en fait nous ne connaissons pas une croissance économique plus vigoureuse que celle qui existait avant 1980. On a l'impression que la situation

the past few years compared to where they were in the previous 10.

The economy we have is the one we have to live with, so that is where the issue of the fox comes in. How do we go about trying to find ways of rebalancing the health care system and making the sorts of innovations that we know need to happen.

Here is an interesting contrast.

We have a crisis in the health care system, both in hospitals and in drugs, but they are different crises. Drug costs are running away with the farm. They are exploding; they are going out of sight. Hospital costs have shrunk until the last year or two. They have shrunk because provincial governments have had control over hospital costs. They did not have control over drug costs, however, and the costs they could not control are going to the moon. They, by the way, have lots of user fees involved in them, and they are simply going to the moon. The hospital costs, where there are no user fees, have been falling.

That does raise an issue of balance. A lot of the drug costs, by the way, are actually increases in prices rather than increases in quantity or effectiveness. A lot of that is just plain old price increases. Conventional economics has badly misrepresented those prices. There is a new thesis that has just come out of B.C. that demonstrates that rather conclusively. That is being examined next week.

Much more of the drug costs than people realize is just plain old price escalation. The market does not control that.

On the other hand, in the hospital sector, we have squeezed out an enormous amount of unnecessary utilization that was there since the beginning of the plants. The patient days per thousand population have been dropping like a stone with all kinds of innovations in surgical day care and other sites and facilities being brought in that should have been brought in long ago, and that were finally brought in by fiscal pressures. Man never reads the writing on the wall until his back is up against it.

What we need to do now is to start taking those processes forward. In the notes that are being distributed to you, I have distinguished between large-scale and small-scale fox type activities. For example, Toronto's national newspaper announced a crisis last winter when the emergency wards were overflowing. You all read the paper; you know it was a catastrophe.

The funny thing was that no such crisis occurred in Alberta. Why not? It was not the user fees. Alberta's public health people had carried out for two years an immunization program against the flu in their long-term care facilities. Consequently, they did not have a crisis. Perhaps Toronto should be thinking of that.

s'améliore parce qu'elle a stagné pendant si longtemps. Comparativement à la situation qui existait au cours des 10 années précédentes, on a l'impression que les choses vont mieux depuis ces quelques dernières années.

L'économie que nous avons est celle avec laquelle nous devons composer; c'est ici que l'approche du renard entre en jeu. Comment pouvons-nous trouver des moyens de rééquilibrer le régime de soins de santé et d'apporter les innovations que nous considérons nécessaires.

Voici un contraste intéressant.

Le régime des soins de santé connaît une crise, tant au niveau des hôpitaux que des médicaments, mais il s'agit de crises différentes. Le coût des médicaments atteint des sommets vertigineux. Ils sont en train d'exploser. Les coûts hospitaliers ont diminué jusqu'à l'année dernière environ. Ils ont diminué parce que les gouvernements provinciaux contrôlaient les coûts hospitaliers. Ils ne contrôlaient pas les coûts des médicaments, toutefois, et ces coûts qu'ils n'arrivaient pas à contrôler ont atteint des sommets vertigineux. Ils comportent d'ailleurs énormément de frais modérateurs et ils augmentent de façon effrénée. Les coûts hospitaliers, où il n'existe pas de frais modérateurs, ont diminué.

Cela soulève une question d'équilibre. Une grande partie des coûts des médicaments, d'ailleurs, représentent en fait des augmentations de prix plutôt que des augmentations en quantité ou un accroissement de l'efficacité. Il s'agit en majeure partie tout bonnement d'augmentation de prix. L'économie classique a présenté ces prix sous un faux jour. Une nouvelle thèse provenant de la Colombie-Britannique le prouve de façon assez concluante. Elle fera l'objet d'un examen la semaine prochaine.

Bien des gens ne se rendent pas compte que les coûts des médicaments sont en grande partie attribuables tout bonnement à l'escalade des prix. Le marché ne contrôle pas ce genre de choses.

Par contre, dans le secteur hospitalier, nous avons éliminé une énorme quantité de choses inutiles qui existaient depuis le tout début. Le nombre de jours-patients a dégringolé grâce aux innovations de toutes sortes dans le domaine de la chirurgie de jour et à la mise sur pied d'autres sites et installations qui auraient dû être établis il y a longtemps et qui l'ont enfin été à cause des pressions financières. On ne voit le signe sur le mur qu'une fois qu'on y est acculé.

Il nous faut maintenant commencer à faire avancer ces processus. Dans les notes qui sont en train de vous être distribuées, j'ai fait la distinction entre les activités à grande échelle et à petite échelle du renard. Par exemple, le journal national de Toronto a annoncé une crise l'hiver dernier lorsque les salles d'urgence étaient bondées. Vous avez tous lu le journal; vous savez que c'était une catastrophe.

Ce qui est étrange, c'est que l'Alberta n'a pas connu de crise semblable? Pourquoi? Ce n'était pas les frais modérateurs. Les responsables de la santé publique de l'Alberta avaient exécuté pendant deux ans un programme d'immunisation contre la grippe dans leurs établissements de soins à long terme. Par conséquent, ils n'ont pas eu à faire face à une crise. Toronto devrait peut-être songer à ce genre de mesures.

That is by no means the only answer. There are many issues around how people in long-term care are looked after. We need some major changes there. One thing we do need there more space; we do not need more space in acute care. That is wrong. Do not look at where the problem is; look at where the problem came from, before you start figuring out a therapy. That is a good basic rule, but that is sort of micro-level, important, but specific-intervention stuff.

On the macro level, the National Forum on Health predicted, among other things, that unless we got a public pharma-care program that was universal and publicly funded, there would be no way of getting drug costs under control. That prediction is looking pretty good. Are we happy with that? The decision seems to have been taken not to go that route, and those costs will continue to escalate.

What we are seeing now, and we saw it in the Quebec plan, is a lot of effort to move the costs from one person's budget to another. Move it off the public budget and move it onto the private sector. Move it to the private insurer; now move it back to the individual. Bring in user charges. That will keep it all under control. No, no. Give it back out to the public and let the public take control of it.

If you engage in a policy of trying to shift costs rather than finding solutions to control costs, you will never succeed in controlling costs. The program of shifting from A to B induces the program of shifting back from B to A, and the costs keep escalating. The Americans have demonstrated that in spades for 30 years. Mr. Zelder is right: we have learned a lot in 30 years. One of the things that we have learned is that that does not work.

What do you do? What you have to find — and this will take fairly aggressive government action — is a way of using the information we already have, both on how to do things **right and** on how to do the right things. That will require, and hear **I start to** overlap a little with Ms Fuller, more coordination between the federal and provincial governments. I think that the Prime Minister has said — although I am not sure publicly — that the EPF arrangements of 1977 were a mistake, because they disconnected the federal government and the provinces.

A basic proposal would be for the federal government to ask the provincial governments what their real priorities are, and they do not have to be the same in each province: "What are your key priorities? Where is the shoe really pinching? We will come to the table with two things: One, money, to help with that; and, two, a willingness to discuss how we will know if our money has been successful in addressing the problem." In other words, some mechanism of joint accountability is required. I do not mean report cards to the population; I mean some way of knowing when you do new stuff and when you bring in new money that you have a strategy for what you will do with the money and how you will know if you have been successful. That does not seem to me to be

C'est loin d'être la seule solution. La façon dont on s'occupe des patients dans les centres de soins de longue durée soulève de nombreuses questions. D'importants changements s'imposent à cet égard. C'est là où nous avons besoin de plus de lits; nous n'avons pas besoin de plus de lits dans les services de soins actifs. Car c'est faire fausse route. Il ne faut pas examiner où se situe le problème mais d'où il vient, avant d'essayer de trouver une solution. C'est une bonne règle de base, mais il s'agit plutôt d'une intervention au niveau local, indépendante mais particulière.

À un échelon macroéconomique, le Forum national sur la santé avait prévu, entre autres, qu'à moins que l'on mette sur pied un programme public d'assurance-médicaments qui soit universel et financé par l'État, il serait impossible de contrôler le coût des médicaments. Cette prédiction est en train de s'accomplir dirait-on. En sommes-nous satisfaits? On semble avoir décidé de ne pas opter pour cette solution, et ces coûts continueront de grimper en flèche.

Ce que nous constatons maintenant et nous l'avons constaté dans le régime en vigueur au Québec, c'est beaucoup d'efforts pour déplacer les coûts d'un budget à un autre, c'est-à-dire les déplacer du budget public au secteur privé. Déplacer ces coûts vers l'assureur privé puis le déplacer à nouveau vers le particulier. Instaurer des frais modérateurs. Cela permettra de les contrôler. Non, non. Il faut que le secteur public assume ces coûts et en assure le contrôle.

Si vous optez pour une politique de déplacement des coûts au lieu d'essayer de trouver des solutions qui contrôleront les coûts, vous n'arriverez jamais à contrôler les coûts. Déplacer les coûts de A à B entraîne un mouvement inverse de B à A, et les coûts ne cessent de grimper. Les Américains le démontrent amplement depuis 30 ans. M. Zelder a raison: nous avons beaucoup appris en 30 ans. L'une des choses que nous avons apprises, c'est que cela ne fonctionne pas.

Que doit-on faire? Il faut trouver — et cela nécessitera des mesures gouvernementales assez vigoureuses — le moyen d'utiliser l'information que nous possédons déjà, tant sur la façon **de bien faire les choses** que sur la meilleure chose à faire. Cela **nécessitera, et je reprends un peu ce que disait Mme Fuller**, une coordination accrue entre les gouvernements fédéral et provinciaux. Je crois que le premier ministre a déclaré — bien que je ne suis pas sûr qu'il l'ait fait publiquement — que l'initiative de financement des programmes établis qui remontait en 1977 était une erreur, parce qu'elle avait provoqué une coupure entre le gouvernement fédéral et les provinces.

Le gouvernement fédéral pourrait essentiellement demander aux gouvernements provinciaux quelles sont leurs réelles priorités, qui ne sont pas forcément les mêmes dans chaque province: «Quelles sont vos principales priorités? Où se situe réellement le problème? Nous arriverons à la table avec deux choses: d'abord de l'argent pour vous aider; et deuxièmement, une volonté de discuter comment nous saurons si l'argent que nous avons fourni a réussi à régler le problème.» Autrement dit, il faut prévoir un mécanisme quelconque de reddition des comptes de part et d'autre. Je ne parle pas des bulletins à la population; je veux dire un moyen de savoir lorsque vous prenez de nouvelles mesures et que vous versez de l'argent neuf que vous avez une stratégie quant

an unreasonable thing to ask for as a general proposition. I believe that is the way we have to go.

On drugs and on home care, you really still do need universal programs, and they can be cost-saving. Down at the micro level, you need — I do not want to use the word “banal,” because they are important — things like immunization programs in long-term care. In the mid-range, you need the structure for better federal-provincial cooperation over target selection, identification of the key problems, putting in the money that we now have, and determining if you have been successful — feedback.

Given those things, we stand a good chance of not drifting into the American catastrophe.

The Chairman: Thank you very much to all three of you. It has been a long time since I have heard three witnesses who were in such complete agreement.

I will resist the temptation to lead off the questioning, because we might never get to anyone else, and I will call upon Senator LeBreton.

Senator LeBreton: In her presentation, Ms Fuller underscored what she believed to be the present debate. She said that the present debate is health as an industry and health as a public service. How will we ever resolve that? What do you think of that statement? How do we, as a country, in a global economy, maintain our identity and our pride in our health care system, and also approach this as “health as an industry”?

Mr. Evans, would you comment on that? Then perhaps Ms Fuller may have something further to add.

Mr. Evans: We all use words in different ways. When I teach health economics, I teach that the health care sector is an industry, in the sense that it absorbs resources and produces commodities and distributes those to people on various terms, but that it is not a business.

You can use the terms anyway you like, but all I mean by that is that the health care sector has the production structure of an industry, but that the incentives that bear on people in that sector are different from normal business incentives. In Canada, as everywhere else in the world, it is predominantly built around not-for-profit hospitals and not-only-for-profit professionals, but it has a significant component of for-profit organization, particularly in the areas of drugs, equipment and so on.

The question then concerns which parts of the sector you want to have organized on standard business principles and with standard for-profit motivations. What are the consequences of doing that, if your objectives are to get to people the care that they need?

à l'utilisation de ces fonds et la façon de savoir si vos efforts ont porté fruit. Cela ne me semble pas une demande déraisonnable de façon générale. Je crois que c'est dans ce sens que nous devons orienter nos efforts.

En ce qui concerne les médicaments et les soins à domicile, il demeure nécessaire de maintenir les programmes universels qui peuvent permettre de réaliser des économies. Au micro-niveau, on a besoin — je ne veux pas utiliser le terme «banales», parce qu'il s'agit de mesures importantes — d'initiatives comme des programmes d'immunisation dans les centres de soins prolongés. Au niveau intermédiaire, il faut une structure susceptible d'améliorer la coopération fédérale-provinciale pour ce qui est d'établir les objectifs, de déterminer les problèmes clés, d'utiliser les fonds disponibles et de déterminer l'efficacité de ces mesures.

Ainsi, nous aurons une bonne chance d'éviter la situation catastrophique qui existe aux États-Unis.

Le président: Je tiens à vous remercier tous les trois. Il y a longtemps que je n'avais pas entendu trois témoins qui étaient aussi d'accord.

Je résisterai à la tentation de poser la première question, car nous risquerions de ne jamais pouvoir entendre les autres; je céderai donc la parole au sénateur LeBreton.

Le sénateur LeBreton: Dans sa présentation, Mme Fuller a souligné ce qu'elle considère être le débat actuel. Elle a dit que le débat actuel porte sur la santé en tant qu'industrie et la santé en tant que service public. Comment arriverons-nous à régler ce problème? Que pensez-vous de cette déclaration? Comment pouvons-nous, en tant que pays dans une économie globale, maintenir notre identité et notre fierté dans notre régime de soins de santé tout en adoptant cette optique de la «santé en tant qu'industrie»?

Monsieur Evans, avez-vous des commentaires à faire à ce sujet? Mme Fuller pourra peut-être ensuite ajouter autre chose.

M. Evans: Nous utilisons tous des mots de façons différentes. Lorsque j'enseigne l'économie de la santé, j'enseigne que le secteur des soins de santé est une industrie, en ce sens qu'il absorbe des ressources et produit des biens qu'il distribue aux gens à diverses conditions, mais qu'il ne s'agit pas d'une entreprise.

On peut utiliser les termes comme on veut, mais tout ce que je veux dire par là c'est que le secteur des soins de santé a la structure de production d'une industrie, mais que les incitatifs dans ce secteur diffèrent des incitatifs commerciaux habituels. Au Canada, comme partout ailleurs dans le monde, ce secteur est surtout axé sur des hôpitaux à but non lucratif et des professionnels qui ne sont pas uniquement motivés par le profit, mais il comporte un élément important d'organisations à but lucratif, surtout en ce qui concerne les médicaments, l'équipement et ainsi de suite.

Il s'agit alors de déterminer les parties du secteur que vous voulez organiser en fonction de principes commerciaux courants, ayant un but lucratif. Quelles en sont les conséquences, si vos objectifs consistent à offrir à la population les soins dont elle a besoin?

If your overriding objective is that people should get what they need, regardless of their ability to pay for it, then that is not something that conventional markets are well adapted to do. When we say that health should be a service, that is what we are saying. We are not saying something about how it is produced and what the industrial structure is, we are saying what do we want the outcomes to be?

The structures should be made to produce the outcomes rather than the other way around. Markets are made for people, not people for markets. You want to choose the appropriate structure to get the result that you want.

Much of the opposition to the intrusion of standard business principles for profit operation has been based on people's concern that it leads to patterns of outcome that are not what they want. A nice way of describing this is through a term introduced by Professor Uwe Reinhardt of Princeton University. That term is the "BSYC".

Has anyone heard of the BSYC? It is a "biological structure yielding cash". There are a number of them around this table and in this room. They can be securitized, and are, as portfolios of covered lives, and they can be used as a basis for generating derivatives, which are then traded in financial markets. Professor Reinhardt, who is a professor of corporate finance, or finance generally, has produced some interesting descriptions of what happens when you start trading portfolios of securitized BSYCs.

You do not get quite the same results as you do when you try to run health care as a public service.

Ms Fuller: I was referring to for-profit health care as opposed to a public service. I agree with Mr. Evans that our terminology is fluid on some of these questions. I am not opposed to a health industry, per se.

However, there is no resolution between the delivery of health care as a way to earn a return on investment and the delivery of health care in a way that upholds the principle of universal entitlement. I am talking about services, not the manufacture of medical equipment or the manufacture and distribution of medical devices and things of that nature.

I am not opposed to the private sector's being involved in the delivery of health services. The system that we have had historically, and should continue to support, is a system that is accountable to the communities in which the services are delivered, and is mainly delivered through the publicly funded non-profit sector. The non-profit sector is much more limited in terms of its ability to earn revenue than the for-profit sector, for obvious reasons. It cannot go to the stock market or to investors, and it cannot incur debt. That is the way in which the for-profit sector is able to earn revenues in addition to user fees.

Si votre objectif principal est d'assurer à la population les soins dont elle a besoin, quelle que soit sa capacité de payer, les marchés traditionnels ne s'y prêtent pas. Lorsque nous disons que la santé doit être un service, c'est précisément ce que nous disons. Nous ne parlons pas de la façon dont on procède ni de la structure industrielle, nous parlons des résultats que nous voulons obtenir.

Les structures devraient permettre de produire les résultats voulus plutôt que l'inverse. Les marchés sont faits pour les gens, pas les gens pour les marchés. Il faut choisir la structure qui permet d'obtenir le résultat escompté.

Une bonne partie du mouvement d'opposition à l'intrusion de principes commerciaux courants axés sur la recherche du profit provient de la crainte que cela donne lieu à des résultats qui ne sont pas les résultats voulus. Le professeur Uwe Reinhardt de l'Université Princeton a trouvé une expression intéressante pour décrire ce phénomène. Cette expression en anglais est «BSYC».

Avez-vous déjà entendu cette expression? Elle signifie «biological structure yielding cash» ou structure biologique à rendement comptant. Il en existe un certain nombre autour de cette table et dans cette salle. Elles peuvent être titrisées, et le sont, en tant que portefeuilles de vies couvertes, et peuvent être utilisées pour produire des instruments dérivés, qui sont ensuite échangés sur les marchés financiers. Le professeur Reinhardt, qui est professeur de financement des entreprises ou de financement en général, a préparé certaines descriptions intéressantes de ce qui se passe lorsque l'on commence à négocier des portefeuilles de BSYC titrisées.

Vous n'obtenez pas tout à fait les mêmes résultats que lorsque vous tâchez d'administrer les soins de santé comme un service public.

Mme Fuller: Je parlais des soins de santé à but lucratif par opposition à un service public. Je suis d'accord avec M. Evans lorsqu'il dit que les termes que nous utilisons pour parler de certaines de ces questions sont élastiques. Je n'ai rien contre l'existence d'une industrie de la santé proprement dite.

Cependant, il y a incompatibilité entre la prestation de soins de santé comme moyen d'obtenir un rendement du capital investi et la prestation de soins de santé d'une manière qui respecte le principe de l'accès universel. Je parle de services et non de la fabrication de matériel médical ni de la fabrication et de la distribution de dispositifs médicaux et de choses de ce genre.

Je n'ai pas d'objection à ce que le secteur privé participe à la prestation de services de santé. Historiquement, notre régime, que nous devrions d'ailleurs continuer d'appuyer, est un régime qui doit rendre des comptes aux collectivités où les services sont assurés, et qui sont assurés principalement par le secteur à but non lucratif subventionné par l'État. Ce secteur à but non lucratif est beaucoup plus restreint au niveau de sa capacité de gagner des recettes que le secteur à but lucratif, pour des raisons évidentes. Il ne peut pas faire appel au marché boursier ni aux investisseurs, il ne peut pas contracter de dettes. C'est la façon dont le secteur à but lucratif arrive à gagner des recettes en plus des frais modérateurs.

I support the delivery of services through the private sector, but not through the for-profit sector, so I would say, yes, let us support and devise ways to develop an industry, but not the development of tools that allow people and investors to earn a return on an investment.

The Chairman: I must ask you a question. I have a huge problem with the underlying logic of your position. You jump from saying that you favour universality — so do I, which would mean that everyone gets the same service — to a conclusion about the person who delivers that service.

Consider a case, for example, where everyone in the country had a voucher, or some kind of credit card, and every time they went for medical assistance the bill was ultimately sent to the government, which would give you all the elements of universality you want. How does that possibly have any implication for the person who actually provides the service? Whether those who provide the service are not for profit, are for profit and losing money, or are for profit and making money, is absolutely unconnected.

You said it perfectly a minute ago. It was a little less obvious in your paper. However, I was troubled by it in your paper. I find a lot of people leap to the conclusion that, if something is universal, that says something about the delivery system as opposed to saying something about what it really is, which is a service being available to people.

I have a difficulty with that leap, which I regard as absolute non-logic.

Ms Fuller: You must look at the source of profit in health care.

The Chairman: Just a minute. Your objective, as clearly stated by you, and by all Canadians, is that everyone wants to have access to the service.

Ms Fuller: Right.

The Chairman: No one around this table would object to that. How does that say anything at all about the person who should deliver the service? They are two separate ends of the issue.

Ms Fuller: First, if you are talking about a public payer, the public purse is not a bottomless well. You do want to have some control over expenditures in health care. Thus a voucher is not offered to people with the message that they can choose between this service over here, which will be delivered by a non-profit entity at cost, with 10 per cent for overhead, or whatever it is, and that service over there, where the same service will be much more expensive. Governments will not do that, and, as a taxpayer, I do not think they should do that. There should be some cost control in the delivery of health care.

J'appuie la prestation de services par l'intermédiaire du secteur privé, mais pas par l'intermédiaire du secteur à but lucratif. Par conséquent, je dirais, oui, appuyons et concevons des moyens de développer une industrie, mais pas de développer des outils qui permettent aux gens et aux investisseurs de toucher un rendement sur le capital investi.

Le président: Je dois vous poser une question. J'ai beaucoup de difficulté à accepter le raisonnement qui sous-tend votre position. D'un côté vous dites que vous êtes en faveur de l'universalité — tout comme moi, ce qui signifie que chacun reçoit les mêmes services — et de l'autre vous tirez des conclusions quant à la personne qui assure ce service.

Prenons un cas, par exemple, où chacun au pays aurait un bon, ou une forme quelconque de carte de crédit et chaque fois que ces personnes recevraient des services de santé, la facture serait au bout du compte envoyée au gouvernement, ce qui assurerait tous les éléments voulus d'universalité. Comment cela peut-il avoir une incidence pour la personne qui se trouve à fournir le service? Cela n'a absolument aucun rapport avec le fait que ceux qui assurent le service n'appartiennent pas au secteur à but lucratif, appartiennent au secteur à but lucratif et perdent de l'argent, ou appartiennent au secteur lucratif et font de l'argent.

Vous l'avez très bien dit il y a un instant. C'était un peu moins évident dans votre document. Quoi qu'il en soit, c'est un aspect de votre document qui me pose problème. Je trouve que beaucoup de gens sautent à la conclusion que si quelque chose est universel, cela fournit une indication à propos du système de prestation plutôt qu'une indication à propos de la situation réelle, à savoir un service offert à la population.

Cette conclusion me pose problème car je considère qu'elle n'a aucune logique.

Mme Fuller: Il faut examiner la source des profits dans le domaine des soins de santé.

Le président: Un instant. Votre objectif, comme vous l'avez énoncé clairement, et comme l'ont énoncé clairement tous les Canadiens, c'est que chacun veut avoir accès au service.

Mme Fuller: Exactement.

Le président: Personne autour de cette table ne s'y oppose. Comment cela peut-il être une indication à propos de la personne qui doit assurer le service? Il s'agit de deux aspects distincts de la question.

Mme Fuller: Tout d'abord, si vous parlez de fonds publics, ils ne sont pas inépuisables. Il faut exercer un certain contrôle sur les dépenses en matière de santé. C'est pourquoi on n'offre pas de bons à la population leur permettant de choisir entre ce service ici qui sera assuré par une entité à but non lucratif au prix coûtant, en prévoyant 10 p. 100 pour les frais généraux permanents, ou quoi que ce soit, et le service offert là-bas, qui sera beaucoup plus coûteux. Les gouvernements n'agissent pas ainsi, et en tant que contribuable, j'estime qu'ils ne le devraient pas. Il faut que l'on exerce un certain contrôle des coûts de prestation des soins de santé.

Second, when investors put their money into something, they expect a return on their investment. That is just the way it works. They do not want to put their money into something and then suffer a loss. If you invest in an entity that will deliver health care, you expect to earn something back.

The Chairman: Of course.

Ms Fuller: The way that you will earn something back should not be from the public purse. I do not believe that.

The Chairman: Your leap of logic is that you have two separate issues. The first is that you do not believe that for-profit organizations should be paid by the public purse, in which case, as an aside, virtually every large corporation in this country is in trouble by virtue of that definition. We will set that aside. They are separate issues that you have linked, although in your current explanation they are clearly divorced.

Mr. Evans: My response to your question would be that you are absolutely right: one does not follow from the other.

I agree with the chairman that the objective of universality does not imply anything one way or the other about the delivery of the services. That is quite correct.

The concern arises from a number of other aspects of the delivery of health care, which would be in place whether or not you had a commitment to a universal public system. After all, the Americans used to have a delivery structure that was much like ours, long before either of us got into the business of trying to develop public insurance programs.

The issue comes down to the protection of vulnerable interests in a situation in which patients in general do not know their own needs. This vulnerable interest language goes back to the Ontario Attorney General's commission on the professions. They got that right about 20 years ago.

When you are dealing with people whose motivations are strictly for profit, that is what the words mean. It is as Vince Lombardi said, "Profit is not the most important thing; it's the only thing." These people develop strategies for enhancing profit. If they do not, then the shareholders will see that their replacements do.

Those strategies have been put nicely in a flyer that came across my desk last week for a conference sponsored by KPMG and one of the other accounting firms. They talked about growing and promoting the evolution of the consumer into a steadily wider range of potential services. That is exactly what we are seeing with for-profit motivation in health care. You see it in the day-care surgery clinics providing cataract services in Alberta — and in B.C. as it turns out. They are going on very quietly, but it is happening. Those services provide the publicly funded care straight up, paid for by my medicare, and then they start sneaking in extra stuff on the side, making claims that are not in fact justifiable about the flexible lens that they will sell you \$700 but that costs approximately £25 to produce. That enhances their profits.

Deuxièmement, lorsque des investisseurs investissent leur argent, ils s'attendent à ce que cet investissement fournisse un rendement. C'est simplement dans l'ordre des choses. Ils ne veulent pas investir dans quelque chose puis subir une perte. Si vous investissez dans une entité qui assurera des soins de santé, vous vous attendez à recevoir quelque chose en retour.

Le président: Bien sûr.

Mme Fuller: Mais il ne faudrait pas que cela se fasse à même les fonds publics. C'est mon opinion.

Le président: Le problème de votre raisonnement, c'est qu'il s'agit de deux questions distinctes. La première, c'est que vous ne croyez pas que les organisations à but lucratif devraient être subventionnées à même les fonds publics, auquel cas, en passant, pratiquement toutes les grandes sociétés dans ce pays sont en difficulté si on se fie à cette définition. Laissons cette question de côté. Il s'agit de questions distinctes que vous avez reliées, même si dans l'explication que vous êtes en train de donner, elles sont clairement séparées.

M. Evans: Ma réponse à votre question, c'est que vous avez tout à fait raison: il n'y a pas d'enchaînement logique.

Je conviens avec le président que l'objectif de l'universalité ne suppose rien d'une façon ou d'une autre à propos de la prestation des services. C'est tout à fait exact.

La crainte provient d'un certain nombre d'autres aspects de la prestation des soins de santé, qui existerait que l'on ait pris ou non un engagement envers un régime public universel. Après tout, les Américains avaient une structure de prestation très semblable à la nôtre, bien avant que nos deux pays essaient d'élaborer des programmes d'assurance gouvernementale.

L'enjeu en question est la protection des intérêts vulnérables dans une situation où les patients en général ignorent leurs propres besoins. L'expression «intérêts vulnérables» remonte à la Commission du procureur général de l'Ontario sur les professions. C'est ce qu'ils ont réussi à faire il y a une vingtaine d'années.

Lorsque vous traitez avec des gens motivés uniquement par le profit, c'est effectivement le sens de ce mot. Comme le dit Vince Lombardi: «Le profit n'est pas la chose la plus importante; c'est la seule chose.» Ces personnes élaborent des stratégies pour augmenter les profits, car autrement les actionnaires s'assureraient de les remplacer par des gens qui en sont capables.

Ces stratégies ont été énoncées de façon intéressante dans une brochure qui a atterri sur mon bureau la semaine dernière en prévision d'une conférence parrainée par KPMG et un autre cabinet d'experts-comptables. On y parle de croissance et de promotion de l'évolution du consommateur dans le cadre d'un éventail de plus en plus vaste de services possibles. C'est exactement ce que nous constatons au niveau du souci de la rentabilité ou du profit dans les soins de santé. On le constate dans les cliniques de chirurgie de jour qui assurent le traitement de la cataracte en Alberta — et aussi en Colombie-Britannique. Cela se fait très discrètement, mais c'est une réalité. Ces services assurent directement les soins subventionnés par l'État, payés par mon assurance-maladie, puis commencent à introduire discrètement des services supplémentaires en faisant des affirmations qui ne sont

The worry is that when I go to see a physician, I want to know that that person is worried about my interests, not his or her profits. In general, in Canada, and in most parts of the world, that is what you get.

The Chairman: That argument I understand. That is a completely different issue, however.

Mr. Evans: That is right. Your point is valid, I think.

Senator Carstairs: Mr. Zelder, in the development of your paper you make much about waiting lists. You compare a number of studies that have been done between Canada and the United States and other countries.

It is interesting, though, that always the great deficits are between the American system and the Canadian system.

How do you explain, then, why Canadians have a longer life span and lower infant mortality rates? In fact, Cubans also have lower infant mortality rates than Americans. How do you explain that, while saying that we have this enormous wait for testing? Is there no relationship between testing or the availability of tests and good health?

Mr. Zelder: As I am sure Professor Evans would agree, the finding is that in developed countries the consumption of health care is not strongly related to life expectancy and other broader measures of health status. However, the question seems to be an important one.

Currently, we are involved in an empirical project at the Fraser Institute where we are looking at waiting times for cardiovascular surgery and cancer radiation treatment. We are looking at the provinces that have longer waiting times for those two types of care to determine if there is a higher mortality rate. In fact, the preliminary results indicate that they do and that there are adverse outcomes. They do not show up at the national level when you encompass all causes of disease and death across all age groups, but they do show up in these particular areas. I believe that to be cause for concern.

Senator Carstairs: The other issue that I would like to discuss is the whole concept of user fees. In my, perhaps naive, opinion, I believe I do pay user fees — they are called taxes. I pay them at the provincial level and at the federal level. What I hope to buy with those taxes is access to quality health care when my family and I need health care services. Why is that not a good system of user fees?

Mr. Zelder: I have not explained myself clearly, then. I was attempting to make the distinction between up-front payments and payments made at the time of use. The point is that, yes, up-front

pas en fait justifiables à propos de lentilles souples qu'ils vous vendront pour 700 \$ mais qui coûtent environ 25 \$ à produire. Cela permet d'augmenter leurs profits.

Lorsque je vais voir un médecin, je tiens à savoir que cette personne se préoccupe de mes intérêts et non pas de ses profits. En général, au Canada et dans la plupart des régions du monde, c'est ce que vous obtenez.

Le président: Je comprends cet argument. Il s'agit toutefois d'une question tout à fait différente.

M. Evans: C'est exact. Votre argument est valable, je crois.

Le sénateur Carstairs: Monsieur Zelder, dans votre document, vous insistez beaucoup sur la question des listes d'attente. Vous comparez un certain nombre d'études qui ont été faites et qui comparent la situation au Canada, aux États-Unis et ailleurs.

Il est toutefois intéressant de constater que les importants écarts se situent toujours entre le régime américain et le régime canadien.

Comment expliquez-vous alors la plus longue longévité des Canadiens et les taux plus faibles de mortalité infantile? En fait, les Cubains affichent aussi des taux de mortalité infantile plus faibles que les Américains. Comment expliquez-vous une telle chose, alors que vous dites qu'au Canada la période d'attente pour les tests médicaux est extrêmement longue? N'existe-t-il aucun lien entre l'administration des tests ou la disponibilité des tests et la bonne santé?

M. Zelder: Comme en conviendra, j'en suis sûr, le professeur Evans, on a constaté que dans les pays industrialisés, il n'existe pas de lien solide entre la consommation des soins de santé et l'espérance de vie et d'autres mesures générales de l'état de santé. Cependant, la question semble être importante.

À l'heure actuelle, nous participons à un projet empirique à l'Institut Fraser où nous examinons les périodes d'attente pour la chirurgie cardio-vasculaire et la radiothérapie dans les cas de cancer. Nous examinons les provinces qui affichent les périodes d'attente les plus longues pour ces deux types de soins afin de déterminer s'il y a un taux de mortalité plus élevé. En fait, les résultats préliminaires indiquent que c'est effectivement le cas et qu'il y a des résultats défavorables. On ne constate pas les mêmes résultats au niveau national lorsqu'on englobe toutes les causes de maladie et de mort dans tous les groupes d'âge, mais ces résultats ressortent dans ces secteurs en particulier. J'estime qu'il y a de quoi s'inquiéter.

Le sénateur Carstairs: J'aimerais discuter aussi de toute cette notion de frais modérateurs. À mon avis, et je suis peut-être naïve, je crois que je paie effectivement des frais modérateurs — c'est ce qu'on appelle des impôts. Je les paie au niveau provincial et au niveau fédéral. Ce que j'espère acheter grâce à ces impôts c'est l'accès à des soins de santé de qualité lorsque ma famille et moi-même aurons besoin de services de soins de santé. Pourquoi n'est-ce pas un bon régime de frais modérateurs?

M. Zelder: Je ne me suis peut-être pas bien expliqué. Je tâchais de faire la distinction entre les paiements forfaitaires uniques et les paiements faits au moment de l'utilisation. Le fait est

payments are made through the tax system, but payments are not made at the time of use of the health care system. The idea of the system is that you make this up-front payment through tax dollars and premiums in two provinces and then you have access to the system for free out of pocket from that point forward. Access to the system is limited, as the waiting list data indicate.

The point about user fees is that a user fee is a fee at the time of use — a fee connected to a particular “doctor visit” or surgical procedure. We do not have those fees in the system. We have up-front fees or payments. Yes, there is payment of a sort for the system, but it is in a way that causes it to work poorly.

Senator Carstairs: Let me give you a specific experience. When I was pregnant with my first child, I went to a gynaecologist-obstetrician who charged a user fee to some young women who went in at that same time, but I was not asked to pay anything. They were asked to put money on the table. I became curious and asked, “Why are they asked to give money and I am not asked to give money?” The explanation was simple, “You will pay at the end, because we will send you a bill and we trust you to pay that bill.”

The visits to an obstetrician’s office are, of course, regularly repetitive. I would see many of the same faces at each of my visits. Then, I noticed that these women dropped off. They dropped off because they could not pay the fee that was required of them at this office. I thought that our system was different and therefore better.

Mr. Zelder: I appreciate what your experience suggests and what intuition suggests to many Canadians, but what I am trying to convey most urgently is that, in fact, that intuition is largely misleading. Yes, low-income people are deterred from consuming care that improves their health if they are required to pay user fees. However, it is not so for the non-poor, who, under this system, are consuming some care that does not benefit their health. The RAND studies indicate that. We should provide no barriers to low-income people in pursuing health care, but, yes, we should erect barriers to those whose incomes can allow it.

Senator Carstairs: That does not make any sense to me, because the wealthier one is in Canada, the healthier one is. Who will pay these user fees? It seems to me that everyone will have to be removed from the equation: the welfare recipients and the working poor and then the middle class, upper middle class and the wealthy people, because they take better care of themselves as they have the financial means to do that, to eat better and lead healthier lives, et cetera. Now who will pay the user fees? It seems to me that there is no one left to pay.

qu’effectivement, les paiements forfaitaires uniques sont faits par le biais du système fiscal, mais les paiements ne sont pas faits au moment de l’utilisation du régime de soins de santé. Ce régime est conçu de façon à ce que vous versiez ce paiement unique forfaitaire par vos dollars d’impôt et vos primes dans deux provinces après quoi vous avez accès au régime sans avoir à déboursier de votre poche à partir de ce stade. L’accès au système est limité, comme l’indiquent les données concernant les listes d’attente.

Quant aux frais modérateurs, il s’agit de frais d’utilisation qui sont versés au moment de l’utilisation — des frais liés à une visite médicale particulière ou à une procédure chirurgicale. Ce genre de frais n’existent pas dans le régime. Nous avons des frais ou des paiements forfaitaires uniques. Oui, le système prévoit un paiement quelconque, mais d’une façon qui nuit à son fonctionnement.

Le sénateur Carstairs: Laissez-moi vous donner un exemple précis. Lorsque j’étais enceinte de mon premier enfant, je suis allée chez un gynécologue-obstétricien qui imposait des frais modérateurs à certaines jeunes femmes qui étaient là en même temps que moi. Pour ma part, on ne m’a rien demandé de payer. On leur a demandé à elles de payer sur-le-champ. Cela a piqué ma curiosité et j’ai demandé: «Pourquoi leur demande-t-on de donner de l’argent et pas à moi?» L’explication était simple: «Vous paierez à la fin, parce que nous vous enverrons une facture et nous savons que vous la paierez.»

Un bureau d’obstétricien reçoit bien entendu la visite régulière des mêmes patientes. Donc je voyais beaucoup des mêmes visages à chacune de mes visites. Puis, j’ai constaté que ces femmes ne venaient plus. Elles ne venaient plus parce qu’elles ne pouvaient plus payer les frais que l’on exigeait d’elles à ce bureau. J’ai pensé que notre système était différent et par conséquent meilleur.

M. Zelder: Je reconnais ce que votre expérience vous laisse supposer et ce que l’intuition laisse supposer à de nombreux Canadiens, mais ce que j’essaie de faire comprendre avant tout, c’est qu’en fait cette intuition est en majeure partie trompeuse. **Oui, on décourage les gens à faible revenu de demander les soins qui amélioreront leur santé** s’ils sont tenus de payer des frais modérateurs ou d’utilisation. Cependant, ce n’est pas le cas pour les gens qui ne sont pas pauvres et qui, en vertu de ce régime, obtiennent des soins qui ne sont pas bénéfiques pour leur santé. C’est d’ailleurs ce qu’indiquent les études de la Fondation RAND. Nous ne devrions pas dresser d’obstacles qui empêchent les gens à faible revenu d’obtenir des soins de santé, mais oui, nous devrions dresser des obstacles pour ceux dont le revenu le permet.

Le sénateur Carstairs: Je n’y comprends rien, puisqu’on trouve au Canada les plus riches et les plus en bonne santé. Qui paiera les frais modérateurs? Il me semble qu’il faudra retirer de cette équation un peu tout le monde: les bénéficiaires de l’aide sociale, les petits salariés, puis les gens de la classe moyenne, les gens de la classe moyenne supérieure et les riches aussi, puisqu’ils prennent mieux soin de leur santé, du fait qu’ils en ont les moyens, qu’ils peuvent manger mieux et vivre des vies plus saines, par exemple. Qui donc paiera les frais modérateurs? Il me semble qu’il ne reste plus personne.

Mr. Zelder: I can assure you, from my own experience and those of my loved ones, that the middle class are not immune to health problems and they too need to use the medical system. All strata of society use health care. To suggest that the poor only use it is just not correct.

Senator Carstairs: I did not suggest that. I asked, "Who will pay these user fees?"

Mr. Zelder: I suggest that everyone in society, except for the poor who should be excluded from paying user fees, will pay these fees under a sensible system.

Senator Carstairs: I am in the top 1 per cent of the income system, so I will not pay user fees, because I will not use these fees.

Mr. Zelder: Of course you will pay them. Everyone who goes to see the doctor must pay them. If you are a high-income person and you go to see the doctor, you will pay user fees.

The Chairman: The issue, Mr. Zelder, which you gloss over, is essentially one that concerns the determination of the dividing line. What is the means by which it is decided that an individual is on one side of the user fee line or the other side?

In the opening statement of your document, Mr. Zelder, there was mention of the "free care ahead" and "no beneficial impacts outside of those sick poor who are approximately 6 per cent of the population". Now, in response to Senator Carstairs' questions, it is suggested that there would have to be a way to make the service available free to the kind of people that the senator indicated would drop off their visits to the obstetrician because they could not pay. Surely the dilemma is determining the mechanism by which the decision is made as to who gets paid and who does not get paid?

One of the underlying tenets of universality, although it was not mentioned explicitly by Ms Fuller, has always been that there shall not be a means test. I do not see a clear way to accomplish your dividing line objective without, in fact, a means test. I noted that in Mr. Zelder's paper care was taken not to use that term. In fact, there is no description of how the dividing line would be drawn.

First, am I correct in saying that under that scheme there would have to be a dividing line? Second, how would the line be drawn? Third, am I right that it is impossible to draw a line without a means test?

Mr. Zelder: Yes, there would be a dividing line to make the system work as to who would be exempted. Yes, to do that would require a means test.

The Chairman: The means test would have to be used.

Mr. Zelder: Yes, the means test would have to be used to exempt low-income people from paying user fees. To ensure that they are not harmed financially then, yes, the means test would be necessary.

The Chairman: How would that be done?

M. Zelder: Je peux vous garantir, d'après ma propre expérience et celle de mes proches, que les gens de la classe moyenne ont parfois des problèmes de santé et doivent avoir recours au système de soins de santé. C'est le cas de toutes les classes sociales. On aurait tort de dire que seuls les pauvres y ont recours.

Le sénateur Carstairs: Ce n'est pas ce que je disais. J'ai demandé qui paiera ces frais modérateurs?

M. Zelder: Je dis qu'avec un régime bien conçu, les gens de toutes les classes sociales paieront ces frais, sauf pour les pauvres, qui ne devraient pas avoir à le faire.

Le sénateur Carstairs: Dans l'échelle des revenus, je fais partie du pourcentage supérieur; je ne paierai donc pas de frais modérateurs, parce que je n'en aurai pas besoin.

M. Zelder: Vous en paierez certainement. Tous ceux qui consultent le médecin devront en payer. Si vous avez un revenu élevé et que vous visitez le médecin, vous paierez des frais modérateurs.

Le président: Monsieur Zelder, vous ne répondez pas à la question: il s'agit essentiellement de déterminer quel sera le seuil. Quel critère servira à déterminer qui en paiera et qui n'en paiera pas?

Dans votre exposé, monsieur Zelder, vous avez parlé des soins de santé gratuits à l'avenir et du fait qu'il n'y aurait pas d'incidences positives, sauf pour les malades pauvres qui représentent environ 6 p. 100 de la population. En réponse aux questions du sénateur Carstairs, on a laissé entendre qu'il faudrait que les services soient gratuits pour le genre de personnes dont le sénateur disait qu'elles n'iraient pas voir leur obstétricien, faute de pouvoir payer. Le problème est sans doute de déterminer comment on décidera qui se fait payer et qui ne se fait pas payer.

L'un des principes de l'universalité, même si Mme Fuller n'en a pas parlé explicitement, a toujours été qu'il n'y aurait pas d'examen des ressources financières. Je ne vois pas comment on peut atteindre votre objectif de distinction entre les divers cas sans qu'il y ait un examen des ressources. Je remarque que dans le document de M. Zelder, on a bien pris soin de ne pas utiliser le terme «examen des ressources». En fait, on ne dit même pas comment on décidera qui paiera et qui ne paiera pas.

Pour commencer, ai-je raison de dire que dans ce régime, il devra y avoir un seuil? Deuxièmement, comment fixera-t-on ce seuil? Troisièmement, ai-je raison d'affirmer qu'il ne peut y avoir de seuil sans un examen des ressources financières?

M. Zelder: En effet, pour que le régime fonctionne, il faut un seuil en deçà duquel on est exempté de payer. Et oui, pour le respecter, il faut un examen des ressources.

Le président: Il faudrait un examen des ressources.

M. Zelder: Oui, il faudrait un examen pour exempter les personnes à faible revenu du paiement des frais d'utilisation. Cet examen des ressources est nécessaire pour s'assurer qu'on ne leur cause pas de problèmes financiers.

Le président: Comment ferait-on?

Mr. Zelder: The test would be based on income and assets. If there were people whose income was lower than a certain level and lower than certain asset holdings, they would not pay out of pocket to access the medical system.

The Chairman: I will return now to the comment on the waiting list issue or the issue in response to Senator Carstairs regarding the differences between the Canadian and the American systems. Senator Carstairs mentioned the lower infant mortality rate and a variety of other things. Surely that has been driven by the universality issue that Ms Fuller talked about. Thus, you are actually proposing that we reinstitute a means test, which was one of the underlying things that was taken out when medicare was started. The real suggestion being argued for right now, after I clear away all of the various arguments, is that a means test is the solution to the problem.

Mr. Zelder: Yes. As I have already said, I believe that a means test would have to be the basis for a compassionate policy.

The Chairman: All right. That one sentence crystallizes what I thought you were trying to say.

Ms Fuller: The means test was dealt with in detail by the Royal Commission on Health Services because it was one of the proposals from the insurance industry and the Canadian Medical Association that people be means-tested to determine whether or not they would be subsidized by the government. The proposal was rejected flat out by the commissioners at that time, not only because of the fact that they felt that Canadians would look at means-testing as a demeaning experience, which it is, but also because of the whole infrastructure that would be required to provide the appropriate support in the effort to determine eligibility for public subsidy. They prepared complicated tables that showed how many people would have to be means-tested according to the proposals from the insurance industry and the Canadian Medical Association. They predicted that, were they to take that route, by the mid-1970s 70 per cent of Canadians would have to be means-tested.

The Chairman: That is the point that Senator Carstairs was making when she questioned who would be left to pay if everyone is exempted.

Ms Fuller: Exactly. That was their calculation at the time and I have no idea what it would be today. They had a very elaborate argument that they countered the insurance industry and the CMA with on the issue of user fees.

The Chairman: Professor Evans, is there anything you would like to add on this one point?

Mr. Evans: It is probably worth noting that Mr. Zelder has talked a lot about the data from the RAND experiment. It is worth noting that that experiment excluded everyone over the age of 62, thereby excluding the most vulnerable parts of the population. Essentially, it showed that people did respond to user charges, but it did not show that the global effect of that response was to affect total costs. That is why we find that, despite heavy user charges in the United States and despite heavy user charges for

M. Zelder: L'examen reposerait sur les revenus et l'actif. Pour les gens dont les revenus sont inférieurs à un certain niveau, ou dont l'actif est inférieur à un montant fixé à l'avance, il n'y aurait pas de déboursés pour l'accès aux soins médicaux.

Le président: Revenons maintenant au commentaire formulé sur la liste d'attente et à la réponse faite au sénateur Carstairs au sujet des différences entre les régimes canadien et américain. Le sénateur Carstairs a parlé du taux de mortalité infantile inférieur et de diverses autres choses. C'est sûrement en réponse à la question de l'universalité dont parlait Mme Fuller. Vous proposez donc que nous rétablissions un examen des ressources financières, soit une des choses qui avaient été éliminées par la création du régime d'assurance-maladie. Si on met de côté toutes sortes d'arguments divers qui ont été invoqués, ce que vous dites actuellement, c'est que l'examen des ressources est la solution au problème.

M. Zelder: Oui. Comme je l'ai déjà dit, je crois que cet examen doit être le fondement d'une politique de compassion.

Le président: Bien. Cette phrase résume ce que je pensais que vous disiez.

Mme Fuller: L'examen des ressources a été traité en long et en large par la Commission royale d'enquête sur les services de santé, parce que c'était l'une des propositions du secteur de l'assurance et de l'Association médicale canadienne qui voulaient qu'on applique un examen des ressources financières pour déterminer si les gens devaient ou non être subventionnés par le gouvernement. Les commissaires ont rejeté carrément cette proposition, à l'époque, non seulement parce qu'ils estimaient que les Canadiens considéreraient que cet examen était humiliant, mais aussi à cause de toute l'infrastructure nécessaire pour déterminer l'admissibilité à une subvention de l'État. On avait préparé des tableaux compliqués qui montraient combien de personnes devraient faire l'objet de cet examen des ressources, d'après les propositions du secteur de l'assurance et de l'Association médicale canadienne. On prédisait qu'en vertu de cette option, au milieu des années 1970, 70 p. 100 des Canadiens devraient faire l'objet de cet examen.

Le président: C'est précisément ce que voulait dire le sénateur Carstairs, lorsqu'elle demandait qui devrait payer, si tout le monde était exempté.

Mme Fuller: Exactement. C'est le calcul qu'on avait fait à l'époque, et je ne sais vraiment pas ce que cela serait aujourd'hui. On avait présenté des arguments très solides pour contrer ceux du secteur de l'assurance et de l'Association médicale canadienne, sur la question des frais modérateurs.

Le président: Professeur Evans, avez-vous quelque chose à ajouter, à ce moment-ci?

M. Evans: Il convient de signaler que M. Zelder a beaucoup fait état des données de l'expérience de la RAND. Mentionnons que cette expérience excluait toute personne de plus de 62 ans, et par conséquent, la partie la plus vulnérable de la population. Les résultats ont montré essentiellement que les gens réagissaient aux frais modérateurs, mais pas l'effet global de cette réaction sur l'ensemble des coûts. C'est pourquoi nous estimons que malgré les frais modérateurs élevés aux États-Unis, et malgré les frais

pharmaceuticals in Canada, those costs actually escalate much faster than the costs in a public system.

Mr. Zelder: That is simply false about there being no effect on total costs. The data clearly indicates a 19 per cent reduction in total costs.

Mr. Evans: We are using different words. We are talking about total costs in different terms. I am talking about the costs of an entire system — American or Canadian.

The Chairman: What do you think Mr. Zelder is talking about?

Mr. Evans: I believe that he is talking about the total costs of the people in the experiment.

Mr. Zelder: I am talking about total spending on health care; it fell by 19 per cent when a 25 per cent co-insurance payment was set.

The Chairman: Yes. I understand what you are saying.

Senator Robertson: Generally speaking, most Canadians have felt that we have a health system and that the Americans do not have health system. Rather, they have bits and pieces all scattered around.

I am worried about where our so-called health system is going and would like to ask each one of you to describe an ideal health system for Canada. Considering the financial aspects and all the problems we have, what do you think would be an ideal health system?

Mr. Evans: An ideal health care system is one that you do not need, speaking as one with considerable experience.

Senator Robertson: I do not believe that because you do not need to go.

Mr. Evans: I am speaking as a patient. I am speaking as one who has done more field work in the last five or six years than anyone should ever want to do. Do you want to know about waiting lists? I can tell you from a patient's point of view about waiting lists, frequency of visits and a host of other things. The best indicator of how a patient is doing, is how frequently the specialist reschedules the visits. When the appointments are two or three times a week, it is not good — forget the user fees. When they are stretched out to two or three months, that is good. Thus, I know clearly that the best kind of health care system is the one that I do not need. That is a sense a frivolous answer, but it ties in with the point that was made about the things that we need to do, other than the health care system, to try to improve our health.

The ideal system is one that we, in principle, know. We can express it quite clearly. We want a system that provides effective, not ineffective, care. That is not something that patients are usually able to judge, but that is what we want. We want effective and compassionate care that is humanely delivered to those who need it and not to those who do not need it. People who want care

modérateurs élevés pour les produits pharmaceutiques au Canada, ces coûts augmentent en fait plus rapidement que ceux du système public.

M. Zelder: Il est tout simplement faux de dire qu'il n'y a pas eu d'effet sur les coûts globaux. D'après les données, il y a clairement eu une réduction de 19 p. 100 des coûts globaux.

M. Evans: Nous employons des termes différents. Nous parlons de coûts globaux de manière différente. Je parle des coûts pour l'ensemble du régime — qu'il soit américain ou canadien.

Le président: Et de quoi parle M. Zelder, d'après vous?

M. Evans: Je pense qu'il parle des coûts globaux pour les sujets de l'expérience.

M. Zelder: Je parle de l'ensemble des dépenses en soins de santé; elles ont baissé de 19 p. 100 lorsqu'un régime de paiement de coassurance de 25 p. 100 a été établi.

Le président: Bien, je comprends ce que vous dites.

Le sénateur Robertson: En général, la plupart des Canadiens estiment que nous avons un régime de soins de santé et que les Américains n'en ont pas. Ils ont plutôt des morceaux de régime, dispersés.

Je m'inquiète au sujet de l'avenir de notre prétendu système de santé et j'aimerais demander à tous les témoins de nous faire une description d'un système de soins de santé idéal pour le Canada. Compte tenu des considérations financières et de tous les problèmes auxquels nous sommes confrontés, quel serait selon vous le système de santé idéal?

M. Evans: Un système de soins de santé idéal est celui dont on n'a pas besoin, et je parle en qualité de personne qui a une énorme expérience.

Le sénateur Robertson: Je ne crois pas que cela puisse être un facteur.

M. Evans: Je parle en tant que patient. Je parle en tant que personne qui a fait un nombre incommensurable d'études sur le terrain au cours des cinq ou six dernières années. Voulez-vous entendre parler des listes d'attente? Je peux vous donner le point de vue du patient quant aux listes d'attente, la fréquence des visites et une foule d'autres choses. Le meilleur indicateur de la santé d'un patient est la fréquence avec laquelle le spécialiste lui donne un nouveau rendez-vous. Lorsqu'il y a deux ou trois rendez-vous par semaine, ce n'est pas bon — oubliez les frais modérateurs. Lorsque les rendez-vous sont échelonnés sur deux ou trois mois, c'est bien. Ainsi, je suis convaincu que le meilleur système de soins de santé qui existe est celui dont je n'ai pas besoin. Cette réponse a l'air fantaisiste, mais elle est en rapport avec la remarque qui a été faite au sujet des mesures qu'il nous faut prendre, non seulement à l'égard du système de soins de santé, en vue d'essayer d'améliorer notre santé.

Le système idéal est celui que, en principe, nous connaissons. Cela peut être exprimé clairement. Nous voulons un système qui fournisse des soins efficaces et non inefficaces. Ce n'est pas une chose dont les patients sont généralement à même de juger, mais c'est ce que nous souhaitons. Nous voulons des soins efficaces et humains qui sont offerts avec compassion aux personnes qui en

when they do not need it are often diagnosed as having Munchausen's syndrome, a form of mental illness. We want the costs kept as low as is reasonably possible; we do not want to pay excessive prices to anyone. We want to spread the burden — and here we get into controversy, but I believe most Canadians want to spread the burden of paying for that care, more or less in terms of ability to pay rather than in terms of the capriciousness of illness.

I believe that you would get, not universal, but quite a broad agreement on that general statement of ideals. When we progress beyond that, then we reach the point of discussions on how to achieve that. We have gone part way on the financing side, but every royal commission — and I participated in one; I have had that privilege — and every other form of public commission that has looked at this has said, "There has to be more explicit management and a better information base to ensure that the care that we are providing is in fact effective, as we hope, and that it is going to the people who need it, as we intend."

We have made considerable strides in that direction but there is still a long way to go. That does not put us behind anywhere else in the world. I am sick and tired of the "bronze medal syndrome" in Canada, which is always to look ahead to see who the leaders in the race are. In a number of respects I think we are, but that does not mean the race is anywhere near over.

Senator Robertson: Mr. Evans, in your perfect health care system, where will the services be delivered? I am not only thinking of a semblance of where it is most appropriate, but how would you like to see the services delivered? Most people think of the health system as the medical profession and the hospitals. With that fact in mind, how would you develop the services?

Mr. Evans: I would certainly want to see more of what is now happening, which is to move the services out of the hospitals, if by "the hospital" we mean a place with a whole lot of in-patient beds. There have been dramatic changes in that respect and there could be substantially more. Acute-care use has been reduced sharply but some of the studies at our shop and other places suggest that, with the appropriately supported home care, you could get still more, particularly medical, not so much surgical, cases out of the hospital.

Surgical cases can be moved to non-in-patient facilities. Whether they be free-standing or coordinated under a general administrative umbrella called a hospital or a regional authority is a question of what works best in a particular setting. When possible, it is preferable to have people awake rather than asleep, and sitting up rather than lying down.

ont besoin et non à celles qui n'en ont pas besoin. Les gens qui veulent des soins dont ils n'ont pas besoin sont souvent diagnostiqués comme souffrant du syndrome de Munchausen, qui est une forme de maladie mentale. Nous voulons que les dépenses soient aussi faibles que possible dans les limites du raisonnable; nous ne voulons pas payer des montants excessifs à qui que ce soit. Nous voulons répartir le fardeau — et c'est là que surgit la controverse, mais je crois que la plupart des Canadiens veulent répartir le fardeau du coût de ces soins, plus ou moins en fonction de la capacité de payer plutôt qu'en fonction du caractère arbitraire de la maladie.

Cet énoncé de principes idéaux, à défaut de faire l'unanimité, serait certainement acceptable pour un grand nombre de gens. Lorsqu'on va au-delà de ces principes, nous devons commencer à discuter de la façon d'y parvenir. Nous avons fait une partie du chemin relativement au financement, mais toutes les commissions royales d'enquête — et j'ai eu l'honneur de participer à l'une d'entre elles — ainsi que toutes les autres sortes de commissions publiques qui se sont penchées sur cette question ont conclu qu'il faut que la gestion soit plus transparente et la base d'information plus complète pour s'assurer que les soins que nous offrons sont bien efficaces, comme nous l'espérons, et qu'ils s'adressent aux gens qui en ont besoin, comme nous le souhaitons.

Nous avons fait de gros progrès dans cette direction, mais il reste encore beaucoup de chemin à faire. Nous ne traînons pas de l'arrière par rapport aux autres pays. J'en ai assez du «syndrome de la médaille de bronze» au Canada, qui consiste toujours à regarder devant pour voir qui mène la course. À certains égards, je pense que c'est nous, mais cela ne veut pas dire que la course soit terminée, bien au contraire.

Le sénateur Robertson: Monsieur Evans, dans votre système de soins de santé parfait, qui se chargera de la prestation des services? Je ne pense pas à ce qui serait vraisemblablement le plus à propos, mais comment souhaitez-vous que ces services soient offerts? La plupart des gens associent le système de santé au corps médical et aux hôpitaux. Compte tenu de cette idée, comment souhaitez-vous développer les services?

M. Evans: Je souhaite sans nul doute que la tendance actuelle se maintienne, à savoir que les services ne soient plus offerts exclusivement dans les hôpitaux, si par «hôpitaux», nous entendons un endroit où il y a un grand nombre de lits pour patients hospitalisés. Il y a eu d'énormes changements à cet égard et il pourrait y en avoir encore beaucoup plus. Le nombre de lits pour soins actifs a considérablement diminué, mais certaines études réalisées par notre organisation et par d'autres nous portent à croire que, grâce à des soins à domicile suffisamment financés, on pourrait faire sortir encore plus de gens de l'hôpital, surtout ceux qui sont là pour des traitements plutôt que pour des chirurgies.

Les malades en chirurgie peuvent être déplacés dans des installations extra-hospitalières. Que ce soit des établissements autonomes ou coordonnés sous les auspices d'une administration générale appelée hôpital ou administration régionale, tout dépend de ce qui est le mieux adapté à un contexte donné. Chaque fois que possible, il est préférable que les gens soient réveillés plutôt qu'endormis, et assis plutôt qu'allongés.

In respect of long-term care, which is the toughest nut to crack — that is where the least progress has been made — the public told those of us on the B.C. Royal Commission loud and clear that they want to go home. That is why our report was called “Closer to Home.” To the extent that it is economically practical, it is preferable to have services delivered in the home, or delivered in facilities that are as home-like as possible. There are obviously both economic and clinical constraints related to that; nevertheless, that is the direction that should be taken.

I strongly believe that the health systems that we know all tend to move the site of care to the most highly trained professional. This is as true in Sweden as it is in the U.S. and in Canada. That seems to be the logical thing to do. However, we have known for 30 years that a great deal of primary care could be provided by nurse practitioners rather than family practitioners. We have proven several times over that a high school graduate with 20 months training can perform most general dentistry. Those sorts of developments, which were actively pursued in the early seventies, were choked off when we suddenly found that we had a dramatic increase in physician supply, brought about by a falling birth rate rather than any plan to increase physician supply. That continued until about eight years ago. It choked off the whole area of re-balancing the type of people who supply health care.

We now have the opportunity to re-open this issue, but there are two constraints. First, all the medical schools are telling us that there will be a shortage of doctors in the future and that, as such, the answer is to “grind out” more doctors. If we do that, we will lose the opportunity for another generation. Second, nursing has changed a lot in 30 years. Nursing leadership now is much less interested in what they might pejoratively call “becoming junior clinicians,” and yet that is where the need exists.

The solution is not to provide alternative types of services in alternative types of settings. A significant advantage would be gained by substituting more appropriate but less extensively trained personnel. When I was a graduate student in the U.S. and then back here in Canada, I always received my care in clinics. The balance of care was downloaded to the person who had the necessary competence but not beyond that. We made that same recommendation in the B.C. Royal Commission 10 years ago. That is part of the change in the mix. As you well know, however, the resistance to that is quite intense.

The Chairman: The resistance is on the part of unions — or “professional associations,” as they prefer to be called. I do not use the word “union” pejoratively, but that is what they are. That is the source of the resistance. What I hear you saying, Professor Evans, is that there is not a lot of disagreement in the country in terms of what the objectives should be but that many of the most

Pour ce qui est des soins prolongés, qui posent le plus de problèmes — c’est dans ce secteur que l’on a enregistré le moins de progrès — les Canadiens qui ont témoigné devant la Commission royale de la Colombie-Britannique nous ont dit clairement qu’ils veulent rentrer chez eux. C’est pourquoi nous avons intitulé notre rapport «Closer to Home.» Dans la mesure où c’est pratique du point de vue économique, il est préférable que les services soient offerts à domicile ou dans des établissements qui rappellent le plus le milieu familial. Cela présente évidemment certaines limites sur le plan économique et clinique, mais il n’en demeure pas moins que c’est la voie à suivre.

Je suis intimement convaincu que les systèmes de santé que nous connaissons ont tendance à confier le soin des patients à l’élite professionnelle. Il en est ainsi en Suède tout comme au Canada et aux États-Unis. Cela semble logique. Toutefois, nous savons depuis 30 ans qu’une bonne partie des soins primaires pourraient être fournis par des infirmiers et infirmières plutôt que par des médecins de famille. Nous avons démontré à maintes reprises qu’un diplômé du secondaire ayant reçu 20 mois de formation peut assurer la plupart des soins dentaires généraux. Ce genre d’initiative, dont on a beaucoup fait la promotion au début des années 70, ont été étouffés dans l’oeuf lorsque nous avons constaté d’un seul coup que nous avions un excédent de médecins, dû à la chute du taux de natalité plutôt qu’à un plan précis pour accroître l’offre de médecins. Cette tendance s’est poursuivie jusqu’à environ huit ans. Cela a étouffé dans l’oeuf toute tentative en vue de rééquilibrer les groupes de professionnels qui offrent les soins de santé.

Nous avons aujourd’hui l’occasion de rouvrir ce dossier, mais il y a deux restrictions. Tout d’abord, toutes les facultés de médecine nous disent qu’il y aura une pénurie de médecins à l’avenir et que, de ce fait, il faut absolument «sortir» plus de médecins. Si nous le faisons, nous perdrons la possibilité pour une autre génération. En second lieu, les soins infirmiers ont énormément changé en 30 ans. Les dirigeants des soins infirmiers sont beaucoup moins enclins à «devenir des cliniciens subalternes» comme on pourrait les appeler de façon péjorative, et pourtant c’est là que le besoin existe.

La solution ne consiste pas à offrir d’autres sortes de services dans d’autres cadres. Nous aurions tout à gagner d’avoir des professionnels qui, s’ils n’ont pas reçu une formation aussi poussée, sont toutefois mieux adaptés aux besoins. Lorsque j’étais étudiant universitaire aux États-Unis et ensuite au Canada, j’ai toujours été soigné dans des cliniques. Le reste des soins était confié à la personne qui possédait la compétence nécessaire mais rien de plus. Nous avons fait la même recommandation à la Commission royale de la Colombie-Britannique il y a 10 ans. Cela fait partie du changement dans la combinaison des services. Comme vous le savez, toutefois, cette idée suscite de vives objections.

Le président: Les objections viennent des syndicats — ou plutôt des «associations professionnelles», comme ils préfèrent s’appeler. Je n’utilise pas le terme «syndicat» de façon péjorative, mais ce sont ni plus ni moins des syndicats. C’est de là que viennent les objections. Si je vous ai bien compris, monsieur Evans, vous dites qu’il existe un certain consensus dans le pays

economical and efficient ways to achieve those objectives are blocked by "entrenched interests" who are arguing for their own private interests above and beyond the broader public interest. Is that a fair one-sentence summary?

Mr. Evans: Yes.

Mr. Zelder: At least three elements make up an ideal health system: first, a user fee for the non-poor; second, non-collectively bargained doctors fees; and third, hospitals that are run without government control of funding and allocation of resources.

Ms Fuller: I will speak as a patient. From a patient's perspective, an ideal health system is one that supports patient autonomy — not just patient autonomy but individual health autonomy — which patients are losing, to some degree, as a result of changes that are taking place. Patient autonomy and patient education are very important.

Another characteristic of an ideal system is cooperation among funders and providers of health care. That does not exist nearly to the extent that we need.

I agree with some of the recommendations that came out of the Seaton commission — not all of them, but a great number of the recommendations regarding the delivery of health care outside of the acute care sector, outside of hospitals, in our communities and in our homes. Community-based care is an ideal level of health care delivery. Institutions should not be the only places where people can access health care services.

There also must be a high degree of public accountability in the provision and funding of health care.

Senator Robertson: I have always felt strongly that health services should be delivered as much as possible in the community — at schools, at the workplace, and at home. It is our own fault, I suppose, that hospitals are so strong.

I am among the few who wonder how much more money the health system needs; the money is being spent in the wrong places, in my opinion. We place the majority of health services under a hospital roof because a hospital is the first 50/50 cost-shared unit. Now, we are having trouble pulling these services out. We are not doing very well across the country in terms of pulling those services out from under hospital roofs. Surely, with today's technology, the hospital should only be taking care of critically ill people, people whose life is threatened or people who suffer from invasive processes. The remaining can be accommodated in less expensive environments.

quant à nos objectifs, mais que certains «groupes d'intérêts intransigeants» battent en brèche les moyens les plus rentables et efficaces d'atteindre ces objectifs parce qu'ils font passer leurs intérêts personnels avant l'intérêt public. Est-ce que cela résume assez bien votre opinion?

M. Evans: Oui.

M. Zelder: Il faut au moins trois éléments pour faire un système de santé idéal: premièrement, un des frais modérateurs pour ceux qui ne sont pas pauvres; en second lieu, des honoraires de médecin non assujettis à une négociation collective et, troisièmement, des hôpitaux gérés sans que le gouvernement n'ait la haute main sur le financement et la répartition des ressources.

Mme Fuller: Je vais parler en tant que patiente. Du point de vue du patient, un système de santé idéal est celui qui favorise l'autonomie du patient — pas seulement celle du patient, mais également de chaque personne — que les patients sont en train de perdre dans une certaine mesure, en raison des changements en cours. L'autonomie et l'éducation des patients sont des éléments très importants.

La collaboration entre ceux qui financent et ceux qui fournissent les soins de santé est un autre aspect d'un système de santé idéal. Cette collaboration est insuffisante à l'heure actuelle.

J'approuve certaines recommandations formulées par la commission Seaton — pas la totalité, mais un grand nombre des recommandations concernant la prestation des soins de santé en dehors des établissements de soins actifs, des hôpitaux, mais plutôt dans les collectivités et dans nos foyers. Les soins communautaires représentent un niveau idéal pour la prestation des soins de santé. Les hôpitaux et cliniques ne devraient pas être les seuls endroits où les gens peuvent obtenir des services de santé.

Il faut également que les responsables de la prestation et du financement des services de santé aient l'obligation de rendre des comptes.

Le sénateur Robertson: J'ai toujours été convaincue que les services de santé devraient être assurés dans la mesure du possible au sein de la collectivité: à l'école, au travail et à la maison. C'est de notre faute, je suppose, si les hôpitaux sont si puissants.

Je fais partie des rares personnes qui se demandent combien d'argent supplémentaire il faudrait investir dans le système de santé; à mon avis, les fonds dont nous disposons sont dépensés à mauvais escient. Nous regroupons la majorité des services de santé sous un toit d'hôpital parce qu'un hôpital est le premier établissement à être financé à parts égales entre les deux paliers de gouvernement. Or, nous avons du mal à déplacer ces services. Nous n'obtenons pas de très bons résultats dans le pays quand il s'agit d'assurer ces services en dehors du milieu hospitalier. Il va sans dire que grâce à la technologie moderne, l'hôpital ne devrait servir qu'à soigner les malades en phase critique, les gens dont la vie est menacée et qui sont atteints de maladies invasives. Les autres personnes peuvent très bien être soignées dans des milieux moins onéreux.

I will read your answers carefully, but I also think there must be horizontal funding in health regions and not vertical funding of every little thing that goes on now.

Senator Callbeck: My question concerns the federal-provincial funding relationship.

Dr. Evans, you said that we need to do the right things in the correct manner. You mentioned the idea of the federal government asking the provinces about their priorities, and that the federal government will want to test the outputs or how effectively the money is being spent.

Ms Fuller, I assume that you believe that cost sharing is better than the block funding. I would like to hear your comments on the federal-provincial health care arrangement.

Dr. Evans, in respect of federal funding to the provinces, what percentage of the money should be coming from the federal government?

Mr. Evans: I would start with a 50/50 split, but I do not know the answer to that.

What I am referring to is new money. I am not talking about shifting from block grants and tax points all the way back to the pre-1997 environment. That does not seem to be realistic. However, it is a question of saying, "We have new money to bring to the table and you have new or old problems. Let us see how we can match those up." As to whether the federal contribution should be 50 per cent, or larger or smaller, that gets into federal-provincial fiscal negotiations and I do not feel I have any competence in that area. However, I would urge the principle involved therein.

I am not sure whether your question was a broader one about what proportion of the funding for health care should be coming from the federal government. Were you also addressing that issue?

Senator Callbeck: Yes.

Mr. Evans: First, for medicare-covered services, the original 50 per cent was not a bad idea. However, it is important not to buy into this nonsense of it being down to about 13 per cent. That seems to be political posturing that is difficult to justify on moral grounds. You do that by throwing in everything in health spending, not simply the things that are covered by health care. You do that by ignoring the whole issue of tax points, which is an important part of the whole picture. You also do that by doing some black artwork on how you can crank out the CHST and allocate it among the different components.

From my point of view as an economist, it would be a good idea if you were to segregate the CHST amount, so that it made sense to allocate x-amount for post-secondary education, x-amount for health, and so on. I expect, however, that that is the

Je vais lire attentivement vos réponses, mais je pense également qu'il faut favoriser le financement horizontal dans des régions de santé et non le financement vertical de la moindre activité qui se déroule.

Le sénateur Callbeck: Ma question porte sur les rapports entre le fédéral et les provinces quant au financement.

Docteur Evans, vous avez dit que nous devons essayer de faire du mieux possible pour atteindre les objectifs visés. Vous avez dit que le gouvernement fédéral pourrait demander aux provinces quelles sont leurs priorités, et qu'il souhaitera évaluer les résultats ou voir dans quelle mesure les fonds sont dépensés, de manière efficace.

Madame Fuller, je suppose que vous êtes d'avis que le partage des frais vaut mieux que le financement global. J'aimerais savoir ce que vous pensez de l'entente fédérale-provinciale relative aux soins de santé.

Docteur Evans, en ce qui concerne les fonds alloués aux provinces, quelle proportion des fonds devrait venir du gouvernement fédéral?

M. Evans: Je commencerais par un partage à parts égales, mais je n'ai pas la réponse à cette question.

Je parle d'injection d'argent frais. Je ne parle pas de passer des subventions globales et des points d'impôt pour en revenir à la situation antérieure à 1997. Cela ne semble pas réaliste. Toutefois, il s'agit de dire: «Nous avons de l'argent frais à mettre sur la table et vous avez des problèmes nouveaux ou anciens. Voyons comment concilier les deux.» Quant à savoir si la contribution du gouvernement fédéral devrait être de 50 p. 100, ou supérieure ou inférieure, cela relève des négociations financières entre les deux paliers de gouvernement et je n'ai pas compétence pour en parler, à mon avis. Toutefois, je préconise vivement le principe inhérent à ces négociations.

Je me demande si votre question était de portée générale, à savoir quelle proportion des fonds alloués aux soins de santé devrait venir du gouvernement fédéral? Est-ce ce dont vous vouliez parler?

Le sénateur Callbeck: Oui.

M. Evans: Tout d'abord, pour les services visés par l'assurance-maladie, la formule des 50 p. 100 prévue au départ n'était pas une mauvaise idée. Toutefois, il importe de ne pas souscrire à l'argument absurde selon lequel le financement a diminué à près de 13 p. 100. Ce sont des arguments purement politiques qu'il est difficile de justifier sur le plan moral. On le fait en regroupant tout dans les dépenses de santé, et pas simplement les services assurés par les soins de santé. On le fait en faisant fi de toute la question des points d'impôt, qui est un élément important du tableau. On le fait également en se livrant à toutes sortes de calculs savants au sujet du TCSPS et de sa répartition entre les divers éléments.

À mon avis, et je parle en tant qu'économiste, ce serait une bonne idée de faire une ventilation des fonds que représente le transfert social pour qu'il soit logique d'attribuer une somme de tant à l'enseignement postsecondaire, de tant à la santé, et cetera.

comment of a complete political neophyte and that it would not make any sense to try it.

It embarrasses me when newspaper reporters or radio interviewers ask me: "What is the federal contribution at the moment?" I reply, "I do not jolly well know. You choose your assumptions and use whatever number you like." Transparency would be better served if we had a better way of segregating money. However, transparency is not always a political virtue. Am I getting anywhere with your question?

Senator Callbeck: Yes.

Ms Fuller: There have always been arguments between the provinces and the federal government about the issue of funding and whether it would be conditional funding, and so on. One of the things that was reinforced, unfortunately, with the introduction of the Canada Health Act was the idea that funding would be used as a club to force compliance with national principles or criteria. In the original discussions about medicare during the 1960s, funding was seen as an enabler; in other words, funding would enable provinces to maintain national standards. However, now, even when Canada is reporting to the UN or to whomever, it refers to net federal funding as something that will force compliance – in other words, if there is no compliance there is no transfer of funds. We need to re-establish a much higher level of federal financial participation in health care funding and to rethink the principles of that funding. Is it only to bash the provinces around or is it to enable them to uphold these conditions in a fair way?

The idea of 50/50 funding is not 50 per cent of Ontario's total health bill, 50 per cent of B.C.'s, and so on, but 50 per cent of national expenditures, which, in theory, would help the provinces meet those national standards.

Mr. Zelder: I agree with Professor Evans that it is impossible now to know how much the federal government spends. As to how it should be divided between the federal government and the provinces, again, that is outside of my bailiwick.

I would caution against the system of matching grants that preceded established program financing. As I mentioned in my paper, a study found that that system reduced the price of health spending for the provinces, because of the matching grants, so they shifted money away from other social programs. There was a distortion. I would discourage the idea of matching grants and recommend more the idea of block funding for health. However, it would be nice if it were transparent.

Je suppose toutefois que cette remarque est digne d'un véritable néophyte politique et qu'il serait absurde de mettre un tel système à l'essai.

Cela me gêne quand des journalistes de la presse écrite ou de la radio me demandent à combien s'élève la contribution du gouvernement fédéral à l'heure actuelle. Je leur réponds que je n'en ai pas la moindre idée, et qu'ils n'ont qu'à faire leurs propres hypothèses et à utiliser le montant qui leur convient. Aux fins de la transparence, il faudrait qu'il existe une meilleure façon de séparer les fonds. Toutefois, la transparence n'est pas toujours une vertu politique. Est-ce que cela répond à votre question?

Le sénateur Callbeck: Oui.

Mme Fuller: Il y a toujours eu des discussions entre les provinces et le gouvernement fédéral au sujet du financement et de la question de savoir si celui-ci devrait être conditionnel, et cetera. L'entrée en vigueur de la Loi canadienne sur la santé a malheureusement eu pour effet de confirmer le principe que le financement servira de bâton pour obliger les provinces à respecter certains critères ou principes nationaux. Lors des discussions initiales au sujet de l'assurance-maladie dans les années 60, le financement était un facteur habilitant; autrement dit, le financement devait permettre aux provinces de maintenir des normes nationales. Toutefois, à l'heure actuelle, même lorsque le Canada fait rapport aux Nations Unies ou à un autre organisme, il parle du financement fédéral net comme d'un facteur inhérent à la conformité — en d'autres termes, si les provinces ne respectent pas les normes, il n'y a pas de transfert de fonds. Il faut rétablir la participation financière du gouvernement fédéral au financement des services de santé à un niveau bien supérieur et revoir les principes de ce financement. Visent-ils uniquement à malmenier les provinces ou à leur permettre de respecter ces normes de façon équitable?

Le principe du financement à parts égales ne signifie pas que le gouvernement fédéral doive payer 50 p. 100 des frais de santé de l'Ontario, 50 p. 100 de ceux de la Colombie-Britannique, et ainsi de suite, mais plutôt 50 p. 100 des dépenses nationales, ce qui en théorie devrait aider les provinces à appliquer ces normes nationales.

M. Zelder: Je conviens avec M. Evans qu'il est impossible aujourd'hui de savoir combien dépense le gouvernement fédéral. Quant à savoir quel devrait être le partage des dépenses entre le gouvernement fédéral et les provinces, là encore cela sort de mon champ de compétence.

Je ferais toutefois une mise en garde contre le système des subventions de contrepartie qui était en place avant le financement des programmes établis. Comme je l'ai dit dans mon exposé, une étude a révélé que ce système a réduit le coût des dépenses de santé pour les provinces, grâce aux subvention de contrepartie, et elles ont donc cessé de financer d'autres programmes sociaux. Cela a eu un effet de distorsion. Je suis contre le principe des subventions de contrepartie et je recommande plutôt le principe du financement global pour la santé. Toutefois, ce serait une bonne chose si le système était transparent.

The larger issue involves reducing the share of public funding. There is a lot of concern about accountability. However, we do not have accountability because there are limited incentives for accountability in the current structure — that is, incentives that exist when private firms either stay in business or go out of business based on how they serve their customers.

Mr. Evans: There was a lot of rhetoric back in the early seventies about 50-cent dollars and the irresponsibility that this generated in the provinces. There were two problems with that. First, as Colleen Fuller has suggested but did not spell out, the actual formulas were not 50 per cent cost sharing, except at the national level. For each province, the amount of money it received depended on the national pattern and not on its own pattern. If you were spending beyond average for the other provinces, you were not spending 50-cent dollars, you were spending 100-cent dollars.

The Chairman: As Ontario and Alberta did?

Mr. Evans: Yes. Furthermore, the actual record from the early seventies is not one of provincial profligate spending on the health care system. There was a lot of worry about it at the time, but it was probably misplaced. When you look back at the historical record, there was a dramatic slowdown in the expansion of spending right after the introduction of medicare coverage for physicians in 1970-71. There was a lot of concern at the time, based both on a misunderstanding of how the formulas actually worked and on the fact that there is always a lag in the production of the statistical data.

Senator Robertson: It seemed back then, when the funding was more equally shared, that the commotion we hear today about getting political credit was non-existent. I worked back then and I do not remember people bashing either the province or the federal government because of the way the spending was split. Back then, the political arms were treating health care as a non-political issue, which it should be. However, we have moved away from that. It would be awfully nice if we could get back to that. Perhaps your separate funding for health might be the first step in keeping it isolated from everything else.

Someone else said that there is no doubt the money goes to health. However, in the budget, higher education, for instance, becomes an issue in a have-not province. From where does the money come? We are in real trouble here.

Perhaps we should have a health budget. I am not concerned so much about the national health care budget but I worry about the per capita issue that is happening now. The smaller provinces cannot possibly keep up with quality health care on a per capita basis.

Mr. Evans: It is a scale of economy.

La question plus générale est liée à la diminution de la part du financement public. On s'inquiète beaucoup de la reddition de comptes. Toutefois, il n'y a pas d'obligation de rendre compte, parce que la structure actuelle comporte peu d'incitatifs à rendre des comptes — je veux parler des incitatifs qui existent lorsque des sociétés privées restent en activité ou font faillite en fonction de la qualité du service qu'elles offrent à leurs clients.

M. Evans: Au début des années 70, on a beaucoup parlé du partage des frais à parts égales et du manque de responsabilité que cela a suscité de la part des provinces. Cette formule présentait deux problèmes. Tout d'abord, comme l'a dit Colleen Fuller sans l'expliquer en détail, les formules ne prévoyaient pas réellement le partage des frais à parts égales, sauf au niveau national. Dans chaque province, les montants reçus du gouvernement fédéral dépendaient de la tendance nationale, et non de ce qui se passait au sein de la province. Si l'on dépensait plus que la moyenne des autres provinces, on ne dépensait pas des dollars à 50 cents, mais la totalité des fonds.

Le président: Comme l'ont fait l'Ontario et l'Alberta?

M. Evans: Oui. En outre, si l'on considère les véritables résultats du début des années 70, on constate que les provinces n'ont pas été très prodigues à l'égard du système de soins de santé. Celui-ci suscitait beaucoup d'inquiétudes à l'époque, mais sans doute pour de mauvaises raisons. Lorsqu'on examine les résultats de l'époque, on constate un ralentissement spectaculaire de l'accroissement des dépenses juste après l'entrée en vigueur de l'assurance-maladie pour les médecins en 1970-1971. Il y avait beaucoup d'inquiétudes à l'époque, à la fois parce qu'on ne comprenait pas comment s'appliquaient véritablement les formules et parce qu'il y avait toujours un retard dans la production des données statistiques.

Le sénateur Robertson: À l'époque, lorsque le financement était réparti de façon plus équitable, il semblait que tout le tralala qu'on fait aujourd'hui pour obtenir une reconnaissance politique n'existait pas. Je travaillais à l'époque, et je ne me souviens pas que les gens aient critiqué la province ou le gouvernement fédéral à cause de la façon dont les dépenses étaient partagées. À l'époque, les secteurs politiques considéraient les soins de santé comme une question apolitique, ce qui est normal. Toutefois, les choses ont bien changé. Ce serait formidable d'en revenir à cette époque. Le financement distinct des services de santé que vous recommandez constituerait peut-être la première étape pour savoir où l'on en est.

Quelqu'un a dit qu'il ne fait aucun doute que les fonds sont dépensés dans le domaine de la santé. Toutefois, dans le budget, l'éducation supérieure, par exemple, devient un problème dans une province défavorisée. D'où viennent les fonds? Nous sommes véritablement dans le pétrin.

Il faudrait peut-être prévoir un budget pour la santé. Je ne m'inquiète pas vraiment du budget national des soins de santé, mais plutôt du problème des dépenses par habitant. Les petites provinces ne peuvent pas continuer d'offrir des soins de santé de qualité grâce au montant par habitant.

M. Evans: C'est une échelle d'économie.

Senator Robertson: It is a scale of economy but they will not be able to do it. It would be nice if we could get back to where it was not a political issue.

The Chairman: I wish to ask a couple of questions — first, with respect to the tax points and, second, on the public funding position of Mr. Zelder.

I have a question on the tax points question, and it is not to say, "I told you so."

I have the advantage that, in 1977, when I was deputy chief of staff to the prime minister, I argued passionately against EPF on the simple ground that — and Senator Fairbairn was with me in the PMO at the time — having been in the government of Nova Scotia and having watched what happened when we moved to block funding for municipalities, it was self-evident that once you gave the money to the provinces via block funding, whether it was cash or tax points, you automatically lost any ability to influence where it went.

With that as background, does it make sense these days, when one thinks of the federal contribution, that one should include tax points that were given away 25 years ago? This concerns your question about how much money the federal government is contributing. It involved a tax cut by the feds and a tax increase by the provinces. However, it was done 25 years ago and it has not been earmarked since then.

When any of you three are doing calculations, do you seriously include that money as part of the federal contribution to health care, or is that ancient history?

Mr. Evans: It depends on the purpose for which you are doing the calculation.

If the question is federal leverage over the provinces under the Canada Health Act, then the tax points could not matter less; they do not exist. If the question is, "Could you get them back again and change them into something else?", the answer is "No". That is water under the bridge. Like Cassandra, being right at the time, old boy, does not get you any extra benefits, it just makes people mad at you afterwards.

On the other hand, if your point is some sort of general, moral or political point that the federal government contributes so little that they should butt out and shut up and not bother us while we get on with doing what we want to do, then on that level the tax points are relevant. That is to say, if you are talking about political or moral credibility or the right to be heard, then the federal government does have a right to be heard because it did give up all that money. It did not just give it up 25 years ago, it is giving it up every year. The effect of that decision continues. In that level of discourse, it seems important to emphasize it.

Le sénateur Robertson: C'est une échelle d'économie, mais elles ne pourront pas le faire. Ce serait bien de revenir à l'époque où cette question n'avait aucune connotation politique.

Le président: J'aimerais poser deux questions: la première au sujet des points d'impôt et la deuxième sur la position que recommande M. Zelder quant au financement public.

J'ai une question concernant les points d'impôt, et je ne veux pas dire: «Je vous l'avais dit.»

Je suis privilégié du fait que, en 1977, quand j'étais chef de cabinet adjoint du premier ministre, je me suis opposé avec véhémence au FPE pour la simple raison que — et le sénateur Fairbairn travaillait avec moi au cabinet du premier ministre à l'époque — après avoir fait partie du gouvernement de la Nouvelle-Écosse et vu ce qui s'est passé lorsque nous sommes passés au système de financement global pour les municipalités, il était évident que, dès l'instant où l'on donnait les fonds aux provinces en vertu du système de financement global, qu'il s'agisse d'espèces ou de points d'impôt, on perdait automatiquement toute capacité d'influer sur l'utilisation de ces fonds.

Cela dit, est-il logique de nos jours, lorsqu'on pense à la contribution du gouvernement fédéral, de tenir compte des points d'impôt qui ont été donnés il y a 25 ans? Cela nous ramène à votre question au sujet du montant de la participation fédérale. Il y a eu une réduction d'impôt de la part du gouvernement fédéral et une augmentation d'impôt de la part des provinces. Toutefois, cela s'est fait il y a 25 ans, et les fonds n'ont pas été affectés à une fin particulière depuis lors.

Lorsque vous faites des calculs, et je m'adresse aux trois témoins, tenez-vous sérieusement compte de cet argent dans le calcul de la participation du gouvernement fédéral au financement des soins de santé, ou est-ce de l'histoire ancienne?

M. Evans: Tout dépend de la raison pour laquelle on fait le calcul.

S'il s'agit de déterminer l'influence du gouvernement fédéral sur les provinces aux termes de la Loi canadienne sur la santé, les points d'impôt n'ont absolument aucune importance; ils n'existent pas. S'il s'agit de savoir si l'on pourrait les récupérer et les transformer en autre chose, la réponse est non. Ce serait en pure perte. Tout comme Cassandra, le fait d'avoir toujours raison ne vous rapporte rien de plus; cela ne fait que rendre les gens furieux contre vous après coup.

En revanche, si votre argument, fondé sur un principe général, moral ou politique, veut que la contribution du gouvernement fédéral est si minime qu'il devrait se retirer, la fermer et nous laisser tranquillement vaquer à nos occupations, alors là les points d'impôt ont une importance. En d'autres termes, si vous parlez de crédibilité politique ou morale ou du droit d'être entendu, le gouvernement fédéral a le droit de donner son avis, puisqu'il a distribué tout cet argent. Il ne l'a pas simplement fait il y a 25 ans, il en donne tous les ans. L'effet de cette décision continue de se faire sentir. À ce niveau du discours, il semble important d'insister sur ce point.

When we went through the national forum exercise, we invited a number of experts from within and outside government to advise us on whether, if the cash component went to zero, there would be anything left. The answer that came back loud and clear was, "It is the cash, stupid!"

The Chairman: Right. That is part of the camp I have been in.

Mr. Zelder: You will be pleased to know that I agree with everything that Professor Evans just said.

With regard to the federal government's leverage, I have done some calculations concerning, given the current CHST contributions, as to whether it be in the financial advantage of any province to opt out of medicare. It appears to me that, at present, both Ontario and Alberta would save money by opting out. That is, if they said, "We will forego all CHST transfers but we will put in place a system based on the Rand health insurance experiment; we will have 19 per cent lower health spending," that saved health spending would exceed the CHST that they would lose. I believe that pressure is real and that it is growing.

The Chairman: I wish to move to Mr. Zelder's comment on public funding. If I must pay \$500 for something — that is, if I funnel it through a third party, which is what I do when I buy insurance and other things — other than pure ideology, why do you place such great emphasis on why public funding is so awful?

Mr. Zelder: The reason for that is the difference in behaviour of managers in publicly run firms versus privately run firms. That difference has been well documented in economic literature; it is not a matter of ideology. It says that government-run enterprises do a worse job than the enterprises run by private interests. That is true in all service industries. A comprehensive study was done. Out of 50 studies, only two showed that government firms performed better. My own analysis of the hospital question shows that, in the majority of cases, private firms deliver care better than do government-run firms. That is my concern about getting the public sector out of the health business, namely, that it would lead to improved care.

The Chairman: You argue that it is not ideological, that it is based on empirical evidence; correct?

Mr. Zelder: That is right. It is economic-based.

Mr. Evans: We do not have enough time to comment here in detail, but there are several different confusions there. One concerns the notion that whatever works in one sector of the economy necessarily works in another. It is a general pattern across the developed world that countries do not rely primarily on government-run firms to run their private economies. They do not rely on private firms to run their hospitals. There are very good

Lorsque nous avons participé au forum national sur la santé, nous avons invité certains experts du gouvernement et de l'extérieur pour nous dire si, à leur avis, il resterait quelque chose si les paiements en espèces étaient supprimés complètement. La réponse nous a été donnée haut et clair: «C'est l'argent en espèces, imbécile!»

Le président: Très bien. J'étais dans le même camp.

M. Zelder: Vous serez heureux d'apprendre que je partage entièrement l'avis que vient d'exprimer M. Evans.

Quant à l'influence du gouvernement fédéral, j'ai fait des calculs pour voir si, compte tenu du montant actuel du TCSPS, il serait avantageux du point de vue financier pour une province de se retirer de l'assurance-maladie. Il me semble qu'à l'heure actuelle l'Ontario et l'Alberta y gagneraient. Je veux dire, si elles disaient: «Nous allons renoncer à tous les transferts au titre du TCSPS, mais nous allons mettre en place un système fondé sur l'expérience de l'assurance-maladie Rand; nos dépenses en matière de santé vont diminuer de 19 p. 100», ces économies réalisées au titre des dépenses en matière de santé seraient plus importantes que le manque à gagner au titre du transfert social canadien. Ces pressions sont à mon avis bien réelles et de plus en plus fortes.

Le président: Je voudrais parler de l'observation de M. Zelder au sujet du financement public. Si je dois payer une chose 500 \$ — c'est-à-dire si je remets cet argent à un tiers, ce qui est le cas lorsque j'achète de l'assurance et d'autres choses — pour d'autres raisons que par pure idéologie, pourquoi accordez-vous une telle importance au mauvais côté du financement public?

M. Zelder: C'est à cause de la différence de comportement qui existe entre les gestionnaires des entreprises publiques et ceux des sociétés privées. Cette différence a été bien documentée dans tous les ouvrages économiques, et ce n'est pas une question d'idéologie. Il est prouvé que les entreprises d'État obtiennent des résultats pires que ceux des entreprises gérées par des intérêts privés. Il en va ainsi dans tout le secteur des services. Une étude exhaustive a été effectuée. Sur 50 études, deux seulement ont révélé que les entreprises d'État avaient un meilleur rendement. Il ressort de l'analyse que j'ai faite du dossier des hôpitaux que, dans la majorité des cas, les entreprises privées l'emportent sur les entreprises d'État pour ce qui est de la prestation des services de santé. C'est ce qui me préoccupe lorsqu'on parle du retrait du secteur public de tout le domaine de la santé, car cela entraînerait une amélioration des soins.

Le président: Vous soutenez que ce n'est pas idéologique, et que cela se fonde sur des preuves empiriques, n'est-ce pas?

M. Zelder: C'est exact. Ce sont des données économiques.

M. Evans: Nous n'avons pas assez de temps pour vous expliquer cela en détail, mais il y a plusieurs sources de confusion différentes. D'une part, la notion que ce qui donne des résultats dans un secteur économique en donnera nécessairement dans un autre. En général, dans tout le monde industrialisé, les pays ne comptent pas uniquement sur les établissements d'État pour diriger leurs économies privées. Ils ne comptent pas sur les

reasons for that. We have recently had a look at some of the evidence on this.

Mr. Zelder's view of the evidence could be described as idiosyncratic. However, it is not widely held by many people in the United States, let alone outside. There is a confusion between "government-run," which would include, say, veterans administration hospitals in the United States or the systems of mental hospitals that we used to have in this country, and "government-funded." It is certainly true that government exerts a great deal of influence on hospitals through the funding mechanism, but to suggest that the Vancouver Hospital or the Toronto Hospital is run in the same way as a government department would seem to be naive.

There is a whole series of things that one could say about that. This is like the problem of taking a textbook off the shelf and saying, "one size fits all." There is an old story about the graduate student at the University of Chicago who fell asleep in class and suddenly realized that he was being asked a question. He jerked awake and said, "I'm sorry, professor. I didn't hear the question but the answer is that the money should be controlled."

Senator Fairbairn: I would not want you to get away today without asking you an Alberta-focused question. I am from Alberta. Listening to you today raises all sorts of questions in my own mind. We have a fairly ferocious battle going on there.

One of the things that makes the debate difficult for people to understand is the phraseology, the words that are used — "private" and "public", "for profit" or "private".

According to the bill, hospitals can contract out to private institutions for certain things. Private institutions will be compensated for those services. The premier told us that Albertans need only take their health card with them, that *that was all that* would be required of them.

The question that keeps being asked is this: If that is the case, are there penalties in the bill for these private institutions if they try to encourage the purchase of other kinds of treatment? Why would a private institution want to get into this business if no profit was involved?

That piece of legislation is causing elation in some quarters and great concern in others. There is a lot of misunderstanding about the terms and, because of that, about why it is even being done, particularly when there are papers that show that the cost issue will not be particularly addressed by this nor will the waiting lists.

Do you have views on this?

Mr. Zelder: I am the only person in this country who has comprehensively studied this issue and has read all of the studies on the performance of private hospitals versus government hospitals. I have clearly pointed out that there are some studies

sociétés privées pour diriger les hôpitaux. Il y a de très bonnes raisons à cela. Nous en avons eu dernièrement un exemple assez flagrant.

L'opinion de M. Zelder quant aux preuves pourrait être qualifiée de très particulière. Toutefois, elle n'est pas partagée par un grand nombre de gens aux États-Unis, et encore moins à l'extérieur de ce pays. Il règne une certaine confusion entre la notion d'établissement «d'État», qui s'applique, disons, aux hôpitaux de l'administration des anciens combattants aux États-Unis ou aux réseaux des hôpitaux psychiatriques qui existaient auparavant dans notre pays, et celle d'établissements qui sont «financés par l'État». Il va sans dire que le gouvernement exerce énormément d'influence sur les hôpitaux grâce au mécanisme de financement, mais de là à dire que l'hôpital de Vancouver ou celui de Toronto est géré de la même façon qu'un ministère, c'est faire preuve de naïveté.

On pourrait dire toutes sortes de choses à ce sujet. C'est un peu comme si l'on prend un manuel scolaire sur une étagère en se disant que cela va à tout le monde. Il y a une vieille histoire au sujet de l'étudiant de l'Université de Chicago qui s'est endormi en classe et qui se rend compte d'un seul coup qu'on lui a posé une question. Il se réveille en sursaut et déclare: «Excusez-moi, professeur. Je n'ai pas entendu la question, mais la réponse est qu'il faut contrôler les dépenses.»

Le sénateur Fairbairn: Je ne voudrais pas vous laisser partir aujourd'hui sans vous avoir posé une question qui est axée sur l'Alberta. Je viens de cette province. Après vous avoir entendu aujourd'hui, toutes sortes de questions me viennent à l'esprit. Il y a une bataille assez féroce qui se déroule dans ma province.

S'il est difficile pour les gens de comprendre le débat actuel, c'est à cause du jargon utilisé: On parle de «privé» et de «public», «à but lucratif» ou «privé».

D'après le projet de loi, les hôpitaux peuvent sous-traiter certains services auprès d'établissements privés. Ces derniers seront indemnisés pour ces services. Le premier ministre nous a dit que les Albertains doivent simplement se munir de leur carte santé, et qu'ils n'auront rien d'autre à faire.

La question que l'on pose continuellement est la suivante: si c'est le cas, y a-t-il dans ce projet de loi des sanctions prévues à l'égard de ces établissements privés s'ils essaient d'inciter les patients à acheter d'autres sortes de traitements? Pourquoi un établissement privé voudrait-il se lancer dans cette activité si ce n'était pas rentable?

Ce projet de loi suscite de l'exaltation dans certains milieux et de vives préoccupations dans d'autres. Il y a de nombreux malentendus au sujet des conditions et, partant, des raisons qui justifient cette mesure, surtout quand certains documents prouvent que cela ne résoudra pas vraiment le problème des coûts ni celui des listes d'attente.

Qu'en pensez-vous?

M. Zelder: Je suis la seule personne dans le pays à avoir étudié cette question de façon exhaustive et lu toutes les études sur le rendement des hôpitaux privés par rapport à ceux de l'État. J'ai signalé clairement que certaines études révèlent que les hôpitaux

that show that government hospitals perform better, unlike Professor Evans and other of that ilk who say that there is absolutely no evidence that private hospitals perform better. That evidence is compelling, despite the misinformation that you have been led to believe.

You asked: Why would a private profit-making firm get into this business? They would do it because they can provide the service at a lower cost. That is the only reason a firm would do so. Patients will not come to private firms if they are not getting as good or better care than they are receiving in public hospitals.

This is a perfect opportunity to test to see if this empirical evidence, which is hardly idiosyncratic, will be demonstrated to be the case in Alberta. It has been disappointing to me that such a modest reform has created such a storm of distortion by so many organizations.

Mr. Evans: It may be that Mr. Zelder has read a great deal more than everyone else, because he has certainly found things that other people have not found.

It is interesting that the bill says that there cannot be any private hospitals in Alberta. It starts off by saying, "No person shall run a private hospital." That is not the issue. They can run facilities that do things that hospitals do, but they are not to be called hospitals.

Senator Fairbairn: They are called private surgical facilities.

Mr. Evans: That is right. That is interesting language.

The Chairman: Senator Robertson can correct me, but somewhere in the late seventies the provinces changed from having departments of welfare to departments of social services, so that there was no longer anyone on welfare but the programs remained the same.

Mr. Evans: That is not a bad analogy. The other thing that is extremely tricky is the whole issue of what "private" means. A professor at the University of Toronto did an extensive monograph for the National Forum on Health on what "private" means. Sorting out the language required quite a monograph. In the paper that some of my colleagues and I have done commenting on the Alberta situation, we used a substantial amount of space at the front end to talk about precisely this point, namely, what it was that was bothering people and what different people meant when they talked about "private" and "public."

Those who say that a substantial part of the health care in this country has always been provided by private physicians are absolutely correct. On the other hand, those physicians are not, in general, units of a multinational for-profit corporation; they are private practitioners in private offices. If they were part of an organization that was primarily interested in its biological structure yielding cash, then I suspect that we would be a lot more nervous when we went to see our physicians. We are nervous enough as it is.

d'État obtiennent de meilleurs résultats, contrairement à M. Evans et à d'autres de son acabit, qui prétendent que rien ne permet de croire que le rendement des hôpitaux privés est meilleur. Les preuves dont nous disposons sont concluantes, malgré la désinformation dont vous avez été l'objet.

Vous m'avez demandé pourquoi un établissement privé à but lucratif se lancerait dans cette activité. Il le fera parce qu'il pourra offrir le service à moindre coût. C'est la seule raison pour laquelle une entreprise le ferait. Les patients ne s'adresseront pas aux établissements privés s'ils ne reçoivent pas des soins aussi bons, voire meilleurs, que ceux dispensés dans les hôpitaux publics.

Nous avons là une occasion idéale de vérifier si ces preuves empiriques, qui ne sont guère singulières, s'avéreront en Alberta. Je suis déçu de constater qu'une réforme aussi modeste a suscité autant de fausses rumeurs de la part d'autant d'organismes.

M. Evans: Il est possible que M. Zelder ait lu beaucoup plus d'études que tout le monde, car de toute évidence il a fait des constatations qui ont échappé aux autres.

Il est intéressant de voir que le projet de loi stipule qu'il ne peut y avoir d'hôpitaux privés en Alberta. Il est dit au début que personne ne doit diriger un hôpital privé. Là n'est pas le problème. On peut diriger des installations qui offrent les mêmes services que les hôpitaux, mais il ne faut pas leur donner le nom d'hôpitaux.

Le sénateur Fairbairn: Cela s'appelle des installations chirurgicales privées.

M. Evans: C'est exact. Voilà un jargon intéressant.

Le président: Le sénateur Robertson pourra me corriger, mais vers la fin des années 70, les ministères du Bien-être social sont devenus des ministères des Services sociaux dans les provinces, de sorte qu'il n'y avait plus personne sur les listes du bien-être, mais les programmes n'ont pas changé.

M. Evans: Cette analogie est valable. L'autre chose qui est extrêmement complexe, c'est la question du sens du terme «privé». Un professeur de l'Université de Toronto a fait une monographie détaillée sur le sens du terme «privé» pour le Forum national sur la santé. Il fallait toute une monographie pour expliquer ce terme. Dans l'article que certains de mes collègues et moi avons rédigé au sujet de la situation en Alberta, nous avons consacré plusieurs paragraphes au début à discuter de ce point précis, à savoir ce qui ennuie les gens et ce que des personnes différentes veulent dire lorsqu'elles parlent de «privé» et de «public».

Ceux qui disent qu'une partie importante des soins de santé ont toujours été assurés par des médecins privés, en d'autres pays, ont tout à fait raison. Par ailleurs, ces médecins ne sont généralement pas au service d'une société multinationale à but lucratif; ce sont des médecins privés qui ont des cabinets privés. S'ils faisaient partie d'une organisation dont le but essentiel est de remplir ses caisses, je suppose que nous serions beaucoup plus nerveux lorsque nous allons consulter. Nous le sommes déjà suffisamment.

The clarification of the language is not impossible, but does take time. It does take several words to sort it all out. In debate, a lot of the discussion has been deliberately attempted to obscure those words.

For my own part, I see no problem at all with the issue of purpose-built special clinics. The notion that they might be more cost effective than just mixing people in with the general run seems to be quite plausible. However, that does not seem to be the issue. The concern about moving out to free-standing facilities is not really the issue. The issue concerns the for-profit orientation and the opportunities that are provided for that motivation to slop over into essentially extra-billing, which is exactly what is happening not only in the Gimble clinic — and I was told about this by a group from Elder College to whom I spoke last week — but also on the North Shore of Vancouver and in Victoria. I do not know the extent, but it is operating on the basis of, “Yes, we have the regular public service that you can get for your card, but there is a special extra service. We will put this lens into your eyeball. It will be there forever. Do you want the ordinary one or the high-quality one?” This is not a decision with which consumers should be faced. It would be as if you had private rooms in hospitals — as we have had for years, and they create no problems for anyone — but you were told, “If you are willing to take and pay for a private room, then we can get you in for your surgical procedure a little faster.” Would we find that troubling? I think we would.

If the “private service” is completely detached from that which is therapeutically important, no one has a problem. However, if the two are linked together, which is what is the most profitable strategy, then we have a problem. That is what is happening in Alberta and that is what the opponents of Bill C-11 are concerned about, namely, that it extends the opportunity for linking together insured services and uninsured services and making the access to the one conditional upon the willingness to pay at whatever price is set for the other. That is cunningly crafted to work its way around the Canada Health Act by the letter of the law, but it is trying to drive a truck through the principle.

Ms Fuller: The question that you asked was: Why would anyone want to get into this business if they could not earn a profit? That is a question that I have asked as well. Following from that question is another one, namely: From where will the profit come? That is the challenge for the people in Alberta with regard to this private hospital. I will call it a private hospital because that is what it is.

There is a lot of tiptoeing around some of the words in the legislation. The government is saying that you can take your Alberta health card and get the services, but what services will be publicly insured on the health plan that will be delivered by the hospital? The hospital will make money from the public health insurance system, from the Workers' Compensation Board, from privately insured patients, and so on. Its source of revenue will be

Il n'est pas impossible de préciser la terminologie, mais cela prend du temps. Il faut utiliser plusieurs mots pour préciser le sens. Lors de ce débat, bien des discussions ont visé précisément à rendre cette question très floue.

Pour ma part, je n'ai rien à redire à l'idée de cliniques spécialisées. L'idée qu'elles pourraient être beaucoup plus rentables qu'un établissement où tout le monde est mis dans le même panier me paraît tout à fait plausible. Toutefois, cela n'est apparemment pas le problème. On ne semble pas vraiment s'inquiéter du passage à des établissements autonomes. Le problème est lié à la vocation de rentabilité et aux possibilités que cette motivation débouche sur la surfacturation, ce qui est exactement la situation non seulement à la clinique Gimble — et j'en ai entendu parler par un groupe du Elder College auquel j'ai parlé la semaine dernière — mais également sur la rive nord de Vancouver et à Victoria. Je ne sais pas exactement comment les choses se passent, mais cet établissement fonctionne selon le principe suivant: «Oui, nous offrons le service public courant que vous pouvez obtenir avec votre carte, mais il y a un service supplémentaire spécial. Nous allons vous faire cette greffe du cristallin. Il sera permanent. Voulez-vous le cristallin ordinaire ou celui de qualité supérieure?» Les consommateurs ne devraient pas être confrontés à ce genre de décision. C'est un peu comme s'il y avait des chambres privées dans les hôpitaux — comme il y en a depuis des années, sans que cela pose de problème à qui que ce soit — mais qu'on vous disait: «Si vous êtes prêt à prendre et à payer une chambre particulière, vous pourrez subir votre opération dans un peu moins de temps.» Cela vous paraîtrait-il inquiétant? Je pense que oui.

Si le «service privé» est tout à fait distinct de ce qui est important du point de vue thérapeutique, alors il n'y a pas de problème. Toutefois, si les deux sont liés, ce qui représente la stratégie la plus rentable, alors il y a un problème. C'est ce qui se passe en Alberta et c'est ce qui préoccupe les adversaires du projet de loi C-11, à savoir qu'il offre la possibilité de faire le lien entre le service assuré et le service non assuré, en rendant l'accès à l'un conditionnel à la volonté de payer n'importe quel prix pour l'autre. Ce principe est conçu de façon astucieuse de façon à contourner la Loi canadienne sur la santé par le texte de loi, mais en fait on s'attaque de plein front au principe même.

Mme Fuller: Vous avez demandé pourquoi un établissement voudrait se lancer dans cette activité si ce n'était pas rentable. C'est une question que j'ai posée également. Cette question entraîne une autre, à savoir: «D'où viendra le bénéfice?» C'est le défi qui se pose aux gens en Alberta à l'égard de cet hôpital privé. Je parle d'hôpital privé parce que c'est exactement ce dont il s'agit.

Dans le projet de loi, on tourne autour des mots. Le gouvernement dit que l'on peut obtenir les services en présentant sa carte santé de l'Alberta, mais quels services seront assurés publiquement grâce au régime de soins de santé qui sera offert par l'hôpital? L'hôpital gagnera de l'argent grâce au régime de santé public, grâce à la Commission d'indemnisation des accidents du travail, auprès de patients qui auront une assurance privée, et

varied. It will not be only from the public purse, it will be from other sources as well.

What I am concerned about with the hospital and with the Gimble eye clinic is that upgrades, and so on, are being offered. When patients go into a Gimble eye centre, they can get a softer lens and little bits and pieces of goodies, and so forth, that are not covered by the public health plan. That is what the people of Alberta are trying to grapple with as well; namely, that if the services are covered on the public health plan is it a problem that the company delivering the services is either for-profit or not for profit? If all the services were to be available without user fees or extra-billing, and so on, that is one question. However, I do not think that is the intent of the hospital.

As you said, why would they do that if they could not earn a profit? The challenge and the dilemma of the hospital is: Where will they earn their profits?

The Chairman: I wish to thank all of you for a fascinating two and one quarter hours. We appreciate you taking the time to be with us today.

The committee adjourned.

cetera. Ses sources de revenu seront diverses. Les recettes ne viendront pas simplement du secteur public, mais également d'autres sources.

Ce qui me préoccupe au sujet de l'hôpital et de la clinique ophtalmologique Gimble, c'est que l'on offre aux patients des versions améliorées, et cetera. Lorsque les patients se rendent dans un centre de soins ophtalmologiques Gimble, ils peuvent obtenir un cristallin plus souple et quelques petits avantages, et cetera, qui ne sont pas remboursés par le régime de santé public. C'est ce avec quoi les Albertains sont également aux prises, à savoir que si les services sont assurés par le régime de santé public, le fait que l'entreprise qui assure le service soit à but lucratif ou non pose-t-il un problème? Si tous les services étaient offerts sans frais d'utilisation ou surfacturation, ce serait une chose. Toutefois, je ne pense pas que ce soit l'intention de l'hôpital.

Comme vous l'avez dit, que fera cette entreprise si elle n'est pas rentable? Le défi et le dilemme auxquels l'hôpital sera confronté sont donc: d'où viendront ces bénéfices?

Le président: Je tiens à vous remercier tous de ces deux heures et quart de débat tout à fait fascinant. Nous vous savons gré d'avoir pris le temps de venir témoigner aujourd'hui.

La séance est levée.



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WITNESSES—TÉMOINS

On Bill C-13

From the National Voluntary Organizations Working in Health:

Penelope Marrett.

From the Council for Health Research in Canada:

David Hill, President;

Ronald Worton, Director of Research.

On the state of the health care system in Canada

From the University of British Columbia:

Robert G. Evans, Director, Population Health Program.

From the Canadian Centre for Policy Alternatives:

Colleen Fuller, Research Associate.

From the Fraser Institute:

Martin Zelder, Director of Health Policy Research.

Sur le projet de loi C-13

Des Associations nationales bénévoles oeuvrant dans le domaine de la santé:

Penelope Marrett.

Du Conseil pour la recherche en santé au Canada:

David Hill, président;

Ronald Worton, directeur de la recherche.

Sur l'état du système de santé au Canada

De l'Université de la Colombie-Britannique:

Robert G. Evans, directeur, Programme de santé des populations.

Du Centre canadien de politiques alternatives:

Colleen Fuller, chercheuse associée.

De l'Institut Fraser:

Martin Zelder, directeur de la recherche sur les politiques de santé.

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Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

*Proceedings of the Standing
Senate Committee on*

*Délibérations du comité
sénatorial permanent des*

Social Affairs, Science and Technology

Affaires sociales, des sciences et de la technologie

Chairman:
The Honourable MICHAEL KIRBY

Président:
L'honorable MICHAEL KIRBY

Wednesday, May 3, 2000
Thursday, May 4, 2000

Le mercredi 3 mai 2000
Le jeudi 4 mai 2000

Issue No. 13

Fascicule n° 13

Sixth and seventh meetings on:
The state of the health care system in Canada.

Sixième et septième réunions concernant:
L'état du système de santé au Canada

WITNESSES:
(See back cover)

TÉMOINS:
(Voir à l'endos)

THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Atkins	Keon
* Boudreau, P.C. (Hays)	Kirby
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Meighen
Cook	Milne
Corbin	Robertson
Fairbairn, P.C.	

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Meighen substituted for that of the Honourable Senator Beaudoin (*May 4, 2000*).

The name of the Honourable Senator Atkins substituted for that of the Honourable Senator LeBreton (*May 4, 2000*).

The name of the Honourable Senator Milne substituted for that of the Honourable Senator Pépin (*April 10, 2000*).

The name of the Honourable Senator Corbin substituted for that of the Honourable Senator Gill (*April 10, 2000*).

The name of the Honourable Senator Gill substituted for that of the Honourable Senator Mahovlich (*April 10, 2000*).

The name of the Honourable Senator Pépin substituted for that of the Honourable Senator F. Robichaud (*April 10, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES AFFAIRES SOCIALES, DES SCIENCES ET DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Atkins	Keon
* Boudreau, c.p. (ou Hays)	Kirby
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Meighen
Cook	Milne
Corbin	Robertson
Fairbairn, c.p.	

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Meighen substitué à celui de l'honorable sénateur Beaudoin (*le 4 mai 2000*).

Le nom de l'honorable sénateur Atkins substitué à celui de l'honorable sénateur LeBreton (*le 4 mai 2000*).

Le nom de l'honorable sénateur Milne substitué à celui de l'honorable sénateur Pépin (*le 10 avril 2000*).

Le nom de l'honorable sénateur Corbin substitué à celui de l'honorable sénateur Gill (*le 10 avril 2000*).

Le nom de l'honorable sénateur Gill substitué à celui de l'honorable sénateur Mahovlich (*le 10 avril 2000*).

Le nom de l'honorable sénateur Pépin substitué à celui de l'honorable sénateur F. Robichaud (*le 10 avril 2000*).

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, May 3, 2000

(18)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 3:45 p.m., the Deputy Chair, the Honourable Marjory LeBreton, presiding.

Members of the committee present: The Honourable Senators Callbeck, Carstairs, Cohen, Cook, Fairbairn, Gill, Keon, LeBreton, Pépin, Robertson (10).

Other senators present: The Honourable Senators Murray, P.C., and Wilson (2).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore.

Also in attendance: The official reporters of the Senate.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see Proceedings of the committee, Issue No. 8.*)

WITNESSES:

From Health Canada:

Cliff Halliwell, Director General, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch;

Abby Hoffman, Senior Policy Advisor;

Frank Fedyk, Acting Director, Canada Health Act Directorate, Policy and Consultation Branch.

The Deputy Chair made a statement.

Ms Hoffman made a statement and together with the other witnesses answered questions.

At 5:27 p.m., the committee adjourned to the call of the Chair.

ATTEST:

OTTAWA, Thursday, May 4, 2000

(19)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 11:04 a.m., the Chairman, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Atkins, Callbeck, Carstairs, Cook, Fairbairn, C.P., Gill, Kirby, Meighen (8).

PROCÈS-VERBAUX

OTTAWA, le mercredi 3 mai 2000

(18)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 15 h 45, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Marjory LeBreton (*vice-présidente*).

Membres du comité présents: Les honorables sénateurs Callbeck, Carstairs, Cohen, Cook, Fairbairn, c.p., Gill, Keon, LeBreton, Pépin et Robertson (10).

Autres sénateurs présents: Les honorables sénateurs Murray, c.p. et Wilson (2).

Également présente: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

En conformité avec l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale de l'état du système de santé au Canada. (*Le texte intégral de l'ordre de renvoi figure dans les Délibérations du comité, fascicule n^o 8.*)

TÉMOINS:

De Santé Canada:

Cliff Halliwell, directeur général, Direction de la recherche appliquée et de l'analyse, Direction générale de l'information, de l'analyse et de la connectivité;

Abby Hoffman, conseillère principale en politique;

Frank Fedyk, directeur intérimaire de la Division de la Loi canadienne sur la santé, Direction des affaires intergouvernementales, Direction générale des politiques et de la consultation.

La vice-présidente fait une déclaration.

Mme Hoffman fait un exposé, puis, avec l'aide des autres témoins, répond aux questions.

À 17 h 27, le comité s'ajourne jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

OTTAWA, le jeudi 4 mai 2000

(19)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 11 h 04, dans la salle 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Atkins, Callbeck, Carstairs, Cook, Fairbairn, c.p., Gill, Kirby et Meighen (8).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore

Also in attendance: The official reporters of the Senate.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see Proceedings of the committee, Issue No. 8.*)

WITNESSES:

As an individual:

Tom Kent.

From the University of Toronto:

Michael Bliss, Professor.

The Chair made a statement.

It was moved by Senator Fairbairn — That a Subcommittee on Veterans Affairs be established, comprising five members, including the Honourable Senators: Atkins, Fairbairn, P.C., Kirby, Pépin and Meighen;

That the subcommittee be authorized to send for persons, papers and records, whenever required, and to print from day to day such papers and evidence as may be ordered by it;

That, pursuant to Section 34 of the Financial Administration Act and Guideline 3:05 of Appendix II of the Rules of the Senate, the committee's authority for certifying accounts payable be conferred on the subcommittee; and

That the committee's power to permit coverage by electronic media of meetings be conferred on the subcommittee.

The question being put on the motion, it was agreed.

Mr. Kent made a statement. Mr. Bliss made a statement. The witnesses answered questions.

At 12:53 p.m., the committee adjourned to the call of the Chair.

ATTEST:

Également présente: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

En conformité avec l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale de l'état du système de santé au Canada. (*Le texte intégral de l'ordre de renvoi figure dans les Délibérations du comité, fascicule n^o 8.*)

TÉMOINS:

À titre personnel:

Tom Kent.

De l'Université de Toronto:

Michael Bliss, professeur.

Le président fait une déclaration.

Il est proposé par le sénateur Fairbairn — Qu'un sous-comité des anciens combattants soit créé et qu'il soit composé de cinq membres, notamment des honorables sénateurs Atkins, Fairbairn, c.p., Kirby, Pépin et Meighen;

Que le sous-comité soit autorisé à inviter à comparaître des témoins et à exiger la production de documents et de dossiers, au besoin, et à faire imprimer au jour le jour les documents et témoignages selon ses instructions;

Qu'en conformité avec l'article 34 de la Loi sur la gestion des finances publiques et la directive 3:05 de l'Annexe II du Règlement du Sénat, le pouvoir du comité de certifier les comptes à payer soit conféré au sous-comité; et

Que le pouvoir du comité d'autoriser la couverture de ses réunions par les médias électroniques soit conféré au sous-comité.

La motion, mise aux voix, est adoptée.

M. Kent fait un exposé. M. Bliss fait un exposé. Les témoins répondent aux questions.

À 12 h 53, le comité s'ajourne jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

EVIDENCE

OTTAWA, Wednesday, May 3, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 3:45 p.m. to examine the state of the health care system in Canada.

Senator Marjory LeBreton (*Deputy Chairman*) in the Chair.

[English]

The Chairman: This is the sixth meeting of the committee to study the health care system. Our witnesses today are from Health Canada. We had hoped to hear from the Canadian Institute for Health Information as well, but there were scheduling difficulties. Therefore, we will hear from them at a later date. The Clerk has sent to your offices, a recent report of the CIHI entitled "Health Care in Canada, the First Annual Report," which presents a broad range of facts about health care funding.

Our witnesses from Health Canada will discuss the evolution of health care expenditure, including private and public spending, long-term trends and their impact, and the rationale for changes in federal funding mechanisms. The witnesses are: Abby Hoffman, Senior Policy Advisor, Health Canada; Cliff Halliwell, Director General, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch; and Frank Fedyk, Acting Director, Canada Health Act Division, Intergovernmental Affairs Directorate, Policy and Consultation Branch. I understand, Ms Hoffman, that you are the lead speaker on behalf of Health Canada.

Ms Abby Hoffman, Senior Policy Advisor, Health Canada: In addition to the two subjects that you identified, we understood that a few comments about the federal role in health, particularly with respect to health care, might be useful to members of the committee as well. I will start with a few comments. These are three rather large topics and I know that we have been given a guideline of approximately 10 minutes for introductory remarks. I will forewarn senators at the outset that I will likely exceed that, so feel free to cut me off at any time that seems appropriate. We will be pleased, obviously, to respond to questions or comments from committee members after these initial comments.

I will begin with a few observations about the federal role in health. Clearly there is not time to describe that role in its entirety, but allow me to touch on some key aspects. We currently describe the federal mission in health as being that of helping the people of Canada to maintain and improve their health. We do that through work in three broad areas. One pertains to national health policy and systems, including in particular our publicly funded health care system. The second area pertains to our work in the fields of health promotion and protection, including disease, illness, and injury prevention. The third area pertains to our particular roles with respect to the health and health care services of First Nations and Inuit.

TÉMOIGNAGES

OTTAWA, le mercredi 3 mai 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 15 h 45 pour examiner l'état du système de santé au Canada.

Le sénateur Marjory LeBreton (*vice-présidente*) occupe le fauteuil.

[Traduction]

La présidente: C'est la sixième réunion que nous tenons pour étudier le système de santé. Nos témoins d'aujourd'hui sont des représentants de Santé Canada. Nous espérons recevoir également des membres de l'Institut canadien d'information sur la santé, mais cela n'a pas été possible aujourd'hui. Ils vont donc comparaître à une date ultérieure. La greffière a envoyé à vos bureaux un récent rapport de l'Institut intitulé «Les services de santé au Canada. Un premier rapport annuel», qui présente toute une série de faits concernant le financement des soins de santé.

Les représentants de Santé Canada discuteront avec nous de l'évolution du financement de la santé, y compris les dépenses privées et publiques, des tendances à long terme et de leurs répercussions ainsi que de la justification des changements dans les mécanismes de financement fédéraux. Nos témoins sont Abby Hoffman, conseillère principale en politique à Santé Canada; Cliff Halliwell, directeur général, Direction de la recherche appliquée et de l'analyse, Direction générale de l'information, de l'analyse et de la connectivité, et Frank Fedyk, directeur par intérim de la Division de la Loi canadienne sur la santé, Direction des affaires intergouvernementales, Direction générale des politiques et de la consultation. Madame Hoffman, je crois que vous serez la première à prendre la parole au nom de Santé Canada.

Mme Abby Hoffman, conseillère principale en politique, Santé Canada: En plus des deux sujets que vous avez mentionnés, nous avons cru comprendre qu'il pourrait être utile aux membres du comité que nous fassions également quelques observations sur le rôle que le gouvernement fédéral joue dans la santé, et surtout les soins de santé. Je commencerai par quelques remarques. Ce sont trois sujets assez vastes et je sais qu'on nous a accordé une dizaine de minutes pour notre déclaration liminaire. Je dois vous avertir tout de suite que je vais sans doute dépasser ce temps, alors n'hésitez pas à me couper la parole dès que vous le jugerez bon. Bien entendu, nous nous ferons un plaisir de répondre à vos questions après ces remarques préliminaires.

Je commencerai par quelques observations concernant le rôle que le gouvernement fédéral joue dans la santé. Je n'ai évidemment pas le temps de le décrire entièrement, mais j'aimerais aborder certains de ses principaux aspects. La mission qui est celle du gouvernement fédéral dans le domaine de la santé, consiste à aider les Canadiens à protéger et à améliorer leur santé. Nous le faisons en travaillant dans trois champs d'activité. Il y a d'abord la politique et les systèmes de santé nationaux, et particulièrement notre système de soins de santé financé par l'État. Il y a ensuite le travail que nous accomplissons sur le plan de la promotion de la protection de la santé, y compris la prévention des maladies et des accidents. Notre troisième champ

Our primary and most visible functions in health care are the following: the provision of financial contributions to provinces and territories in support of their health care systems and, to a much more modest extent, to individuals through tax measures such as the medical expense allowance; interpreting and enforcing the principles of the Canada Health Act; ensuring access to community-based health care services for First Nations and Inuit; and working in partnership with the provinces, territories, and key stakeholders such as health provider groups, to strengthen and adapt the Canadian health care system to current and anticipated changes, including changes in health needs associated with such phenomena as population aging.

In addition to those quite explicit roles related to health care, much of our other work in Health Canada does have a direct or indirect contribution to the health care system. Many of our key health protection and regulatory roles are very important. For example, we ensure that Canadians have the benefit of timely access to safe and effective drugs and products. We also ensure that Canadians are protected from health risks associated with elements in the health care system, or pertinent to the health care system, such as pharmaceuticals, blood products, medical devices and so on.

As you know, we are both conductors and, more importantly, funders of health research. We spend a lot of energy, in conjunction with various organizations in the non-governmental sector, on the development of a health information infrastructure.

Through cooperation with other partners, and our own Laboratory Centre for Disease Control, we have many responsibilities of a coordinating and leadership nature in the provision of epidemiological and health surveillance data.

We are also responsible for the development of national disease control strategies in collaboration with provinces and territories. Those would include areas such as cancer, heart health, HIV, AIDS and so on.

There is very little that we do entirely on our own. Collaboration with the provinces and territories on a broad range of health and health care issues is strongly embedded in the health sector, and certainly in our work.

[Translation]

The recognition of a federal role in health, and focussed federal-provincial-territorial collaboration on health issues, has been a distinguishing and very long-standing feature of the health centre. While provincial governments have primary responsibility for health care delivery, the field of health is not assigned exclusively to either order of government.

d'action concerne les services de santé et de soins mis à la disposition des Premières nations et des Inuits.

Nos principales fonctions, qui sont aussi les plus visibles, dans le domaine des soins de santé sont les suivantes: nous apportons une contribution financière aux provinces et aux territoires pour soutenir leurs systèmes de soins de santé et, dans des proportions beaucoup plus modestes, aux particuliers, par l'entremise des mesures fiscales, comme la déduction des frais médicaux; nous interprétons et faisons appliquer les principes de la Loi canadienne sur la santé; nous assurons aux Premières nations et aux Inuits l'accès à des services de santé communautaire et nous travaillons en collaboration avec les provinces, les territoires et les principaux intervenants, tels que les groupes de fournisseurs de soins, pour consolider le système de soins de santé canadien et l'adapter aux changements actuels et prévus, y compris l'évolution des besoins associés à un phénomène comme le vieillissement de la population.

En plus de ces rôles assez explicites en ce qui concerne les soins de santé, une bonne partie du travail que nous accomplissons à Santé Canada contribue, de façon directe ou indirecte, au système de santé. Un grand nombre des principales fonctions que nous remplissons, sur le plan de la protection de la santé et de la réglementation, revêtent une grande importance. Par exemple, nous veillons à ce que les Canadiens puissent avoir accès à des médicaments et des produits sûrs et efficaces. Nous veillons également à ce qu'ils soient protégés contre les risques associés à certains éléments du système de santé ou qui s'y rapportent, tels que les produits pharmaceutiques, les produits sanguins, les dispositifs médicaux, etc.

Comme vous le savez, nous faisons, mais surtout, nous finançons de la recherche dans le domaine de la santé. En collaboration avec divers organismes du secteur non gouvernemental, nous consacrons beaucoup d'efforts à la mise en place d'une infrastructure d'information sur la santé.

Dans le cadre de notre coopération avec d'autres partenaires et de notre propre Laboratoire de lutte contre la maladie, nous assumons de nombreuses responsabilités de coordination et de direction pour la diffusion de données épidémiologiques et la surveillance médicale.

Nous sommes également chargés d'élaborer les stratégies nationales de lutte contre la maladie en collaboration avec les provinces et les territoires. Cela comprend des maladies comme le cancer, les maladies cardiaques, le VIH, le sida, etc.

Il y a très peu de chose que nous faisons à nous seuls. La collaboration avec les provinces et les territoires, pour tout un éventail de questions de santé, joue un très grand rôle dans le secteur de la santé, et certainement dans nos travaux.

[Français]

La reconnaissance du rôle du gouvernement fédéral en matière de santé et la collaboration intergouvernementale sur les questions de santé sont des caractéristiques distinctives et très anciennes du secteur de la santé. Même si les gouvernements provinciaux assument la responsabilité de la prestation des soins de santé, le domaine de la santé ne relève pas exclusivement de l'un ou l'autre des gouvernements.

[English]

There are very well-established and well-developed mechanisms for intergovernmental collaboration in health. I will not dwell on these, but suffice it to say, health ministers, as you may know, meet at an annual conference, and, depending on their respective mutual agendas, sometimes more frequently. Deputy ministers meet formally twice a year at least, and again, informally more frequently, as required.

Four very important expert committees support those deputy ministers and ministerial-level interactions. One works in the areas of population health — for example, with respect to the health surveillance and immunization of children. Another committee deals with health services. High on that agenda, for example, are health human resources, and physician and nursing issues in particular. The other two committees are concerned with health information infrastructure.

These committees, incidentally, have significant membership from the non-governmental sector, from both NGOs and the academic community. They have perhaps worked quietly, but nonetheless very expertly and effectively.

Obviously, the Government of Canada acts as a facilitator and coordinator on health issues with pan-Canadian dimensions. Recent examples that have an impact on the health care system include the development of a strengthened blood supply system, and initiatives such as the Health Transition Fund, which provided \$200 million through the 1997 budget to support provincial, territorial and national innovations in home care, pharmacare, primary care, and integrated health services.

Our role in health care is clearly long-standing and extensive. I want to underscore that, by its very nature, it is carried out in partnership with provinces and territories and in collaboration with stakeholders and citizens.

Let me move now to the subject of the evolution of federal funding for health. Much of what I will try to highlight is covered in two handouts that are being tabled today. These documents are entitled "Health Care Expenditures in Canada: The Key Facts" and "Health Care Expenditures in Canada: Sources of Financing."

I want to cover several areas. This is even more complicated than recent media campaigns would have us all believe. I will try to touch on some of the main points, and my colleagues can respond in greater detail when this initial presentation is complete.

I will first say a word or two about growth in health spending. If one looks at changes by decade, there is no question that the rate of growth in health care spending in Canada did slow considerably from the double digit rates in the 1970s and early 1980s to rates well below 5 per cent per annum in the 1990s.

[Traduction]

Il existe des mécanismes bien établis et bien conçus pour assurer une collaboration entre les gouvernements dans le domaine de la santé. Je ne m'attarderai pas sur le sujet, mais il suffit de dire que, comme vous le savez sans doute, les ministres de la Santé tiennent une conférence chaque année et parfois plus souvent, selon leurs programmes respectifs. Les sous-ministres se réunissent officiellement au moins deux fois par an, et ils tiennent également des réunions informelles plus fréquentes, au besoin.

Quatre comités d'experts très importants appuient cette interaction au niveau des sous-ministres et des ministres. L'un d'eux s'intéresse à la santé de la population, par exemple en ce qui concerne la surveillance médicale et la vaccination des enfants. Un autre s'occupe des services de santé. Parmi ces priorités figurent, par exemple, les ressources humaines, et notamment les médecins et les infirmières. Les deux autres comités se spécialisent dans l'infrastructure d'information sur la santé.

Sois dit en passant, ces comités comptent de nombreux représentants du secteur non gouvernemental, à la fois des ONG et du milieu universitaire. Peut-être ont-ils travaillé dans l'ombre, mais avec beaucoup de compétence et d'efficacité.

De toute évidence, le gouvernement canadien joue le rôle de facilitateur et de coordonnateur en ce qui concerne les questions de santé ayant une dimension pancanadienne. Parmi les exemples récents qui ont eu des répercussions sur le système de santé figurent la mise en place d'un meilleur système d'approvisionnement en sang et des initiatives comme le Fonds pour l'adaptation des services de santé, qui a obtenu, dans le budget de 1997, 200 millions de dollars pour financer les innovations provinciales, territoriales et nationales dans le domaine des soins à domicile, de l'assurance-médicaments, des soins primaires et des services de santé intégrés.

Le rôle que nous jouons dans les soins de santé ne date pas d'hier et est très important. Je tiens à souligner que nous le jouons, nécessairement, en collaboration avec les provinces et les territoires de même que les diverses parties prenantes et les citoyens.

Je voudrais maintenant passer à l'évolution du financement fédéral de la santé. Une bonne partie de ce que je vais vous dire figure dans deux documents que nous déposons aujourd'hui. Ces documents s'intitulent «Dépenses de santé au Canada. Principaux faits» et «Dépenses de santé au Canada. Sources de financement».

Je voudrais aborder plusieurs questions. C'est encore plus compliqué que les campagnes récemment lancées dans les médias voudraient nous le faire croire. Je vais essayer d'aborder certains des principaux points, et mes collègues pourront répondre à vos questions plus en détail lorsque j'aurai terminé.

Je dirai d'abord un mot ou deux au sujet de la croissance des dépenses au chapitre de la santé. Si l'on examine les changements survenus d'une décennie à l'autre, il ne fait aucun doute que la croissance des dépenses au titre de la santé a ralenti énormément depuis les années 70 et le début des années 80, tombant de plus de 10 p. 100 à moins de 5 p. 100 par an dans les années 90.

We must be careful how we interpret the extent and the significance of the slowdown because raw numbers are a little misleading. We need to take into account the much higher levels of inflation in the 1970s and early 1980s compared with single digit inflation in the latter part of the 1980s and the 1990s, and our current very low levels.

In terms of public and private spending, through the mid 1970s into the 1980s, both public and private spending grew at more or less similar rates. However, in the 1990s, the slowdown in public spending on health was considerably more pronounced, with a number of years of little growth or even modest declines.

I want to underscore “modest declines.” The value of public health care spending in the 1990s was not slashed dramatically, as is often claimed. It simply did not grow as much, and again the documents we have tabled provide you with further detail.

[Translation]

And, by the end of the 1990s, as governments for the most part put fiscal deficits behind them, public expenditures started rising again, at a pace similar to private expenditures. The net result was a decline in the public share of total Canadian health expenditures in the 1990s.

When one adjusts spending for overall population growth and general inflation, the slowdown in public spending — indeed the decline in the mid-1990s — becomes more apparent.

[English]

In other words, the mid 1990s was clearly a period when public health expenditures did not keep pace with overall, albeit low, inflation rates and population growth. However, with the rebound in public health expenditures in the late 1990s, the overall level of public spending regained its peak of the early 1990s in terms of real per capita expenditures, even after adjusting for population growth and the general rise in price levels.

The fastest growth rate in recent years has been in the area of drugs, with slower growth in hospitals and physician spending, which had dominated — particularly hospital expenditures — health care spending in the early days of medicare in the 1960s. One reason why the public share of total expenditures has decreased is because private expenditures are more important in that fastest growing area, namely drugs.

Let me comment now on sources of financing, and particularly the history of federal transfers to the provinces. The federal government has always been an important contributor to provincial revenues to help support the provinces in providing Canadians with services in such areas as social security, education,

Il faut interpréter avec prudence la portée et l'importance de ce ralentissement étant donné que les chiffres peuvent être trompeurs. Il faut tenir compte du niveau d'inflation beaucoup plus élevé qui existait dans les années 70 et au début des années 80 par rapport à la fin des années 80 et aux années 90, ainsi que du niveau actuel qui est très bas.

Pour ce qui est des dépenses publiques et privées, au milieu des années 70 et les années 80, elles ont augmenté à un rythme à peu près équivalent. Néanmoins, dans les années 90, le ralentissement des dépenses publiques au chapitre de la santé a été beaucoup plus marqué. La croissance a été faible ou il y a même eu un léger déclin au cours de certaines années.

Je souligne qu'il s'agit d'un «léger déclin». Dans les années 90, la valeur des dépenses publiques pour la santé n'a pas diminué énormément, comme on le prétend souvent. Leur croissance n'a tout simplement pas été aussi prononcée, et les documents que nous avons déposés vous fournissent plus de précision à ce sujet.

[Français]

Ainsi à la fin des années 90, alors que les gouvernements ont réussi à effacer une grande partie du déficit, les dépenses publiques ont recommencé à augmenter à un rythme semblable aux dépenses du secteur privé. On obtient comme résultat net une diminution des dépenses totales du secteur public en matière de santé au Canada dans les années 90.

Si on rajuste les dépenses en fonction de l'inflation en général et de l'augmentation de la population, le ralentissement des dépenses publiques et même leur baisse au milieu des années 90 apparaît plus clairement.

[Traduction]

Autrement dit, le milieu des années 90 est certainement une période où les dépenses publiques au chapitre de la santé n'ont pas suivi le même rythme que le taux d'inflation, même s'il a été faible ou que la croissance démographique. Toutefois, lorsque ces dépenses ont augmenté à la fin des années 90, elles ont regagné le sommet atteint au début des années 90 sur le plan des dépenses réelles par habitant, même si l'on tient compte de la croissance démographique et de l'augmentation générale des prix.

Ces dernières années, ce sont les dépenses consacrées aux médicaments qui ont augmenté le plus rapidement tandis que la croissance a été plus lente en ce qui concerne le coût des médecins et surtout des hôpitaux, qui représentait des dépenses les plus lourdes au début de l'assurance-maladie, dans les années 60. Une des raisons pour lesquelles les dépenses publiques ont diminué par rapport au total, est que les dépenses privées sont plus importantes au chapitre des médicaments, secteur où la croissance est la plus rapide.

J'aimerais maintenant parler des sources de financement, et surtout des transferts fédéraux aux provinces. Le gouvernement fédéral a toujours apporté une contribution importante aux recettes provinciales pour aider les provinces à fournir des services aux Canadiens dans des domaines comme la sécurité sociale,

and health. Equalization, as you know, has certainly been a very significant source of revenue for the less well-off provinces.

In brief, the following is the evolution of federal contributions. Prior to 1977, we cost-shared specific hospital and physician expenditures on a 50/50 basis with the provinces. If a province spent more, the federal government paid half of that incremental amount. In 1977, the federal government replaced cost-sharing for social programs with the EPF, Established Programs Financing. EPF consisted of both cash and a transfer of tax points, or tax room, to the provinces, giving them more own-source revenues. This evolution was, significantly, a function of the provincial desire for greater flexibility in generating revenue to meet their own priorities, and in spending revenues, however sourced, in ways that they felt best served their needs.

1996 saw the advent of the Canada Health and Social Transfer that replaced both the EPF and the Canada Assistance Program, which had previously supported provincial social security. Again, the provinces gained more flexibility in how they split the transfers among the three areas of social security, post-secondary education, and health. Clearly, as we all know, the CHST represented a cut in cash transfers at a time of broad cutbacks in federal spending to address the deficit situation. However, the value to the provinces of the tax point portion of the CHST continued to grow as the economy grew.

The net result of expenditure restraints that had been instituted, and better economic performance and concomitant reductions in public deficits, meant that additional cash could be put back into the CHST.

In 1998, the CHST cash floor was raised, eliminating a previously planned cut. In the 1999 budget, \$11.5 billion was added over a period of four years. Of that amount, \$3.5 billion was put into a CHST trust fund for the provinces, giving them flexibility to draw on those funds as they saw fit over the ensuing four years. They could take all the money at once or have it flow to them at a slower pace.

In Budget 2000, a further \$2.5 billion was put in trust for the provinces to draw from, but in contrast with both the trust and the incremental CHST cash in 1999, the monies in 2000 could be used for any of the three areas and not for health care exclusively.

If the provinces draw from these various amounts in an orderly fashion over the time periods in question, federal cash transfers in 2000-2001 will still fall short of the level of 1995-1996 — that is, prior to the introduction of the CHST — by about \$3 billion. That is the essence of the provincial position on transfers that we hear constantly.

On the other side, when one takes into account the value of the tax points, which continue to grow with the economy through the 1990s, total CHST transfers in 2000-2001 — that is, cash and tax

l'éducation, et la santé. Comme vous le savez, la péréquation a certainement été une source très importante de revenu pour les provinces moins bien nanties.

Voici, en quelques mots, quelle a été l'évolution des contributions fédérales. Avant 1977, nous partageons de moitié avec les provinces certaines dépenses reliées aux hôpitaux et aux services de médecin. Si une province dépensait davantage, le gouvernement fédéral payait la moitié du montant supplémentaire. En 1977, le gouvernement fédéral a remplacé le partage du coût des programmes sociaux par le FPE, le Financement des programmes établis. Le FPE se composait de paiements en espèces et d'un transfert de points fiscaux, ce qui permettait aux provinces d'accroître leurs sources de revenu. Cette évolution résultait du désir des provinces de disposer d'une plus grande marge de manoeuvre pour obtenir les revenus dont elles avaient besoin pour répondre à leurs propres priorités, et dépenser leurs revenus de la façon qui répondait le mieux à leurs besoins.

En 1996, le Transfert canadien en matière de santé et de programmes sociaux a remplacé le FPE et le Régime d'assistance publique du Canada, qui avaient financé jusque-là les programmes provinciaux de sécurité sociale. Encore une fois, cela a laissé une plus grande latitude aux provinces pour répartir les transferts entre la sécurité sociale, l'enseignement postsecondaire et la santé. Comme chacun sait, le TCSPS représentait une réduction des paiements en espèces au moment où le gouvernement fédéral réduisait ses dépenses pour résorber le déficit. Toutefois, la valeur des points fiscaux a continué de croître au fur et à mesure que l'économie a progressé.

La limitation des dépenses, associée à un meilleur rendement économique et à une réduction du déficit de l'État, a permis d'injecter des fonds supplémentaires dans le TCSPS.

En 1998, le gouvernement a relevé le plancher des transferts en espèces du TCSPS, renonçant à une réduction qui avait été prévue. Dans son budget de 1999, il a ajouté 11,5 milliards de dollars sur une période de quatre ans. Sur ce montant, 3,5 milliards ont été mis dans un fonds de fiducie où les provinces pouvaient puiser de l'argent, selon leurs besoins, au cours des quatre années suivantes. Elles pouvaient sortir tout l'argent d'un coup ou progressivement.

Dans le budget de l'an 2000, 2,5 milliards de plus ont été mis dans un fonds de fiducie pour les provinces, mais contrairement à ce qui avait été prévu en 1999, cet argent pouvait servir à l'un des trois domaines inclus dans le programme, et pas seulement à la santé.

Si les provinces puisent régulièrement de l'argent au cours de la période en question, en 2000-2001, les transferts en espèces fédéraux resteront quand même inférieurs d'environ 3 milliards de dollars, à leur niveau de 1995-1996, c'est-à-dire avant la mise en place du TCSPS. Telle est la situation que font constamment valoir les provinces à l'égard des transferts.

Par contre, si on tient compte de la valeur des points d'impôt, dont la croissance a suivi celle de l'économie pendant toutes les années 90, en 2000-2001, la valeur totale du TCSPS, c'est-à-dire à

room — will exceed the value of the transfer in 1995-1996. This is the essence of the federal position.

Before leaving federal expenditures, I wish to say that it is difficult, as has been reported in the media and recently in the document that you received from the Canadian Institute for Health Information, to determine exactly how much the federal government spends on health because of the flexibility under the CHST. When one calculates federal contributions to health using the same notional apportioning among health, post-secondary education and social security as existed in the pre-CHST days under the combined effects of EPF and CAP, the federal government is contributing \$1 out of every \$3 spent on health by public authorities in Canada. That is a subject of debate at the moment, but it is undeniable that it is a one-in-three share of public spending.

We will respond to the questions and comments you have later. I will now continue with the third topic, namely, the evolution of federal legislation related to health care insurance.

The delivery and means of financing health services on a universal basis has been a long-standing subject of study. It was the subject of several commissions in the 1930s and 1940s. I will not dwell on that history, but universal, publicly financed health insurance effectively began in 1947, when the Province of Saskatchewan introduced a public insurance scheme for hospital services. About nine years later, the federal government offered to cost-share hospital and diagnostic services, similar to those available to residents of Saskatchewan, on a 50/50 basis to encourage the development of similar hospital insurance programs in all provinces. That led in 1957 to the federal Hospital Insurance and Diagnostic Services Act, which required provinces wishing to participate and receive federal contributions to provide universal coverage for a minimum range of federally defined in-patient hospital services on uniform terms and conditions. It took about four years for all provinces to choose to meet those conditions and participate.

[Translation]

In 1964, the Royal Commission on Health Services reviewed the health system and recommended that the federal government also enter into agreements with the provinces to share the costs of comprehensive, universal medical care for their residents, sustaining the view that pre-paid access to medically necessary physician care for all Canadians was equitable, cost-effective and socially responsible.

[English]

The enabling legislation, the Medical Care Act, was proclaimed in July 1968. The principles that provincial medical care insurance plans had to meet in order to be eligible for what then became federal cost-sharing were the following, recognized as four of the five principles of the Canada Health Act today: public administration of their health insurance plans on a non-profit

la fois les transferts en espèces et les points d'impôt, dépassera le niveau de 1995-1996. Telle est la position du gouvernement fédéral.

Avant de passer à un autre sujet, je tiens à dire qu'il est difficile, comme on l'a dit dans les médias, et récemment dans le document que vous avez reçu de l'Institut canadien d'information sur la santé, d'établir exactement combien le gouvernement fédéral consacre à la santé, étant donné que le TCSPS laisse une grande marge de manoeuvre. Lorsqu'on calcule la contribution fédérale à la santé en faisant la même répartition entre la santé, l'enseignement postsecondaire et la sécurité sociale que pour le FPE et le Régime d'assistance publique, avant l'entrée en vigueur du TCSPS, chaque fois que les gouvernements canadiens consacrent 3 \$ à la santé, le gouvernement fédéral donne 1 \$. C'est actuellement un sujet de discussion, mais il est indéniable que sa part correspond au tiers des dépenses publiques.

Nous répondrons plus tard à vos questions et à vos observations. Je vais maintenant continuer en passant au troisième sujet, à savoir l'évolution de la législation fédérale relative à l'assurance-santé.

La prestation et le financement des services de santé sur une base universelle fait l'objet d'études depuis des années. Plusieurs commissions se sont penchées sur la question dans les années 30 et 40. Je n'en retracerai pas l'historique, mais l'assurance-santé universelle financée par l'État, est entrée en vigueur en 1947, lorsque la Saskatchewan a mis sur pied un régime d'assurance publique pour les services hospitaliers. Environ neuf ans plus tard, le gouvernement fédéral a offert de défrayer la moitié des services d'hôpitaux et de diagnostic, comme ceux dont bénéficiaient les résidents de la Saskatchewan, afin d'inciter toutes les provinces à offrir le même genre de programmes d'assurance-hospitalisation. C'est ce qui a mené, en 1957, à la Loi fédérale sur l'assurance-hospitalisation et les services diagnostiques, qui exigeait que les provinces, désireuses de participer au programme et d'obtenir une contribution du fédéral, assurent une protection universelle pour une série de services hospitaliers définis par le gouvernement fédéral, à des conditions uniformes. Il a fallu environ quatre ans pour que toutes les provinces décident de respecter ces conditions et de participer au programme.

[Français]

En 1964, la Commission royale d'enquête sur les services de santé a recommandé au gouvernement fédéral de conclure avec les provinces des ententes sur le partage des coûts de services de santé complets et universels pour les citoyens, affirmant que l'accès sans frais aux soins de santé pour tous les Canadiens était équitable, rentable et responsable sur le plan social.

[Traduction]

La loi habilitante, la Loi sur les soins médicaux, a été proclamée en juillet 1968. Les principes que devaient respecter les régimes d'assurance-santé des provinces pour être admissibles au programme de partage des coûts étaient quatre des cinq principes qui sont aujourd'hui ceux de la Loi canadienne sur la santé: le Régime d'assurance-santé devait être géré sans but

basis; insurance of a comprehensive range of medical services; universal coverage of insurable residents; and portability of coverage within Canada. Some provinces had already met these criteria and joined the program immediately; others took several years. However, by 1972 all provinces and territories were participating.

Earlier, I described some of the movement from cost-sharing to per capita entitlement, so I will not dwell now on the corresponding funding mechanisms for health insurance.

[Translation]

After Justice Hall's subsequent review of the Health Insurance Program in 1979, he reported that health care in Canada ranked among the best in the world, but warned that extra billing by doctors — requiring patients to supplement what a doctor was paid by the provincial plan and user fees levied by hospitals.

[English]

For example, registration costs, per diem copayments, and so on. Justice Hall's view was that we were threatened with a two-tier system that would endanger access to care.

In response to these concerns, in 1984 Parliament unanimously passed the Canada Health Act, which replaced the Hospital and Diagnostic Services Act and the Medical Care Act. There were several key points in the Canada Health Act worth noting, including the affirmation of universal insurance as the basis for medically necessary hospital and physician services, and the strengthening of the principles of portability, comprehensiveness, and public administration. A fifth criterion, accessibility, was added — that is, reasonable access to medically necessary insured services on uniform terms and conditions. Further, and perhaps most importantly, there was to be an effort to discourage user charges and extra billing. The CHA provided for mandatory dollar-for-dollar deductions from federal transfer payments to any province that permitted user charges or extra billing for insured services.

As you know, each province and territory operates and manages its own health care system that respects the principles of the CHA with financial assistance from the federal government, resulting effectively in 13 individual but interlocking plans. To receive full cash contributions, provinces and territories must be in compliance with the act.

I will now address my last point, which deals with the services that are and are not governed by the principles of the Canada Health Act. There are five of them.

First, there are insured services. Under the comprehensiveness criterion of the CHA, provincial and territorial health insurance plans must insure all medically necessary hospital, physician, and surgical dental services. However, the act does not define

lucrative par une autorité publique; le régime devait couvrir tous les services de santé assurés; tous les résidents assurés d'une province devaient être couverts et la garantie devait être transférable dans les autres provinces. Certaines provinces avaient déjà respecté ces critères et adhéré immédiatement au programme tandis que d'autres ont mis plusieurs années à le faire. Toutefois, en 1972, toutes les provinces et territoires y participaient.

J'ai décrit tout à l'heure comment s'était fait le passage du partage des coûts au transfert par habitant et je ne vais donc pas m'étendre sur les mécanismes de financement correspondant pour l'assurance-santé.

[Français]

Après la révision du programme d'assurance-maladie en 1979, la juge Hall a conclu que les soins de santé dispensés au Canada étaient parmi les meilleurs au monde. Elle a toutefois fait une mise en garde concernant la surfacturation des médecins qui obligent les patients à payer une somme supplémentaire au montant que reçoit le médecin en vertu du régime provincial et les frais modérateurs demandés par les hôpitaux.

[Traduction]

Par exemple, les frais d'enregistrement, la quote-part des frais journaliers, et cetera. La juge Hall a estimé que nous risquons de nous retrouver avec un système à deux niveaux qui compromettrait l'accès aux soins.

À la suite de ces préoccupations, le Parlement a adopté à l'unanimité, en 1984, la Loi canadienne sur la santé qui remplaçait la Loi sur l'assurance-hospitalisation et les services diagnostiques ainsi que la Loi sur les soins médicaux. Plusieurs dispositions importantes de la Loi canadienne sur la santé méritent d'être soulignées, notamment le principe de l'universalité pour les services hospitaliers et médicaux ainsi que le renforcement des principes de transférabilité, d'intégralité et de gestion publique. Un cinquième critère, l'accessibilité a été ajouté. Autrement dit, il faut permettre un accès raisonnable aux services assurés et médicaments nécessaires, à des conditions uniformes. De plus, et c'est peut-être le plus important, on a cherché à dissuader et d'imposer un ticket modérateur ou une surfacturation. La Loi canadienne sur la santé prévoyait que toute province qui autorisait l'imposition d'un ticket modérateur ou une surfacturation pour les services assurés se verrait déduire un montant équivalent de ces paiements de transfert.

Comme vous le savez, chaque province et territoire exploite et gère son propre régime de soins de santé conformément aux principes de la LCS avec l'aide financière du gouvernement fédéral, le résultat étant 13 régimes distincts mais imbriqués les uns aux autres. Pour obtenir la totalité des contributions en espèces, les provinces et les territoires doivent se conformer à la loi.

J'aborderai maintenant le dernier point, à savoir les services qui sont régis par les principes de la Loi canadienne sur la santé, et ceux qui ne le sont pas. Il y en a cinq.

Tout d'abord, les services assurés. En application du principe de l'intégralité de la LCS, les régimes d'assurance-maladie des provinces et des territoires doivent assurer tous les services de santé fournis par les hôpitaux, les médecins ou les dentistes,

“medical necessity.” That is determined through negotiations between provincial medical associations and departments of health. In reality, medical practitioners commonly determine medical necessity in the course of their interactions with and provision of care and treatment to patients. Some things, however, are more clearly defined as not medical necessary — for example, cosmetic surgery. There is flexibility.

Second, extended health care services are the variety of community and institutional programs and services, including long-term care and certain aspects of adult residential home and ambulatory care, that are subject only to the conditions of the Canada Health Act, which means information is to be provided and the federal contribution is to be recognized. However, copayments, that is supplementary charges, may be levied for such services, and indeed are.

Third are supplementary health care services or additional benefits. These are the health services that provinces and territories have offered over time, perhaps on a universal basis, but with various terms and conditions added that effectively abridge the degree of universality. I am talking about prescription drug programs, chiropractic services, physiotherapy, dental services, and so on. Since these services do not fall under the CHA, only certain population groups may be eligible — seniors or children, for example, or individuals on social assistance — and copayments, deductibles, and so on may also be levied.

Fourth, there are uninsured services. I gave you the example earlier of cosmetic surgery.

More problematic perhaps are services that have been deemed non-insured by provincial legislation or regulation. One example that definitely affects the way in which primary care is delivered is that telephone advice is not an insured service. If you want to get advice from your physician and the physician wants to be able to bill the provincial medical scheme for that advice, say for commentary on tests that you may have received, you have to visit the doctor's office. He or she cannot give you that advice over the telephone as a billable service. It does not mean it does not happen; it just means it is not a billable service.

Finally, there are de-insured services, again a category that is often exaggerated. From time to time, in the negotiations between provincial medical associations and their respective health departments, various services, whether it is wart removal or wisdom teeth extraction or whatever, have been removed from the list of insured services.

We are now ready to take your questions.

The Chairman: Thank you. It was a very comprehensive and good explanation of the Canada Health Act.

Senator Robertson: Ms Hoffman, I wish we had received some of these documents earlier to study. It would have helped considerably. I find them coming in at this time very difficult. They are very important, but it is difficult to properly analyze

nécessaires sur le plan médical. Toutefois, la Loi ne définit pas ce que l'on entend par «nécessité médicale». Celle-ci est déterminée lors de négociations entre les associations provinciales de médecins et les ministères de la Santé. Dans la pratique, les praticiens décident souvent ce qu'est la nécessité médicale lors de leur interaction avec les malades et lorsqu'ils leur fournissent des soins et des traitements. Certains services, toutefois, sont plus clairement exclus de la nécessité médicale, la chirurgie plastique, par exemple. Il y a une certaine latitude.

Deuxièmement, les services complémentaires de santé englobent l'ensemble des programmes et services de proximité et en établissement, y compris les soins de longue durée et certains aspects des soins en résidence pour adultes et des soins ambulatoires, qui sont assujettis uniquement aux conditions de la Loi canadienne sur la santé, ce qui signifie que des renseignements doivent être fournis et que la contribution fédérale doit être reconnue. Toutefois, une quote-part, c'est-à-dire des frais supplémentaires, peut être, et est, exigée pour ces services.

Il y a ensuite les services de soins de santé complémentaires ou services additionnels. Il s'agit des services de santé que les provinces et les territoires offrent depuis longtemps, peut-être sur une base universelle, mais assortis de diverses modalités et conditions, ce qui en fait entame l'universalité. Je parle des programmes de médicaments sur ordonnance, les services de chiropractie, de physiothérapie, les services dentaires, etc. Puisque ces services ne sont pas visés par la LCS, seuls certains groupes de la population peuvent y avoir droit — les personnes âgées ou les enfants, par exemple, ou les assistés sociaux — et une quote-part ou une franchise peut aussi être imposée.

Quatrièmement, il y a les services non assurés. Je vous ai donné l'exemple tout à l'heure de la chirurgie plastique.

Ceux qui causent sans doute plus de problèmes sont les services jugés non assurés par une loi ou un règlement provincial. Par exemple, les conseils donnés au téléphone ne sont pas un service assuré, ce qui modifie tout à fait le mode de prestation des soins primaires. Si vous voulez obtenir des conseils de votre médecin et que celui-ci veut pouvoir facturer le régime d'assurance-maladie de la province, pour commenter les résultats de tests que vous pouvez avoir subis, il vous faudra vous rendre à son cabinet. Le médecin ne peut pas vous donner ces conseils au téléphone et facturer le service. N'allons pas en déduire que cela ne se passe pas; cela signifie seulement que ce n'est pas un service facturable.

Il y a enfin les services désassurés, une catégorie que l'on a souvent exagérée. Il arrive à l'occasion, lors des négociations entre les associations provinciales de médecins et les ministères de la Santé, que divers services, comme l'ablation d'une verrue ou l'extraction d'une dent de sagesse, soient supprimés de la liste des services assurés.

Nous sommes maintenant disposés à répondre à vos questions.

La présidente: Merci. Vous nous avez donné une explication complète et excellente de la Loi canadienne sur la santé.

Le sénateur Robertson: Madame Hoffman, j'aurais aimé recevoir certains de ces documents à l'avance pour les étudier. Cela nous aurait beaucoup aidés. Le fait de les avoir maintenant me complique la vie. Ils sont très importants, mais il est difficile

them without a little time. I hope that perhaps after we have had a chance to look at these, we may have another opportunity to ask questions. Really, you cannot make sensible comments on something you receive five minutes before a meeting starts.

Ms Hoffman, I want to start by being very elementary. What interested me the most in your discussion was the comprehensiveness principle. I know you had to go quickly to get through it all. Would you tell me, please, from your national perspective, what is health care that is covered by medicare? What is to be included in the comprehensiveness principle? Just repeat that for me, please.

Ms Hoffman: Perhaps I can just start by briefly commenting on what I said, and then I will ask Mr. Fedyk, who is the acting director of the responsible division, to provide some more detail.

In sum, under the comprehensiveness criteria of the CHA, provincial and territorial health insurance plans must insure all medically necessary hospital, physician, and surgical dental services to eligible persons in the particular province. I then went on to say that medical necessity is not defined anywhere in legislation, and therefore is a matter of negotiation that may give rise to some differences from province to province.

Mr. Frank Fedyk, Acting Director, Canada Health Act Division, Intergovernmental Affairs Directorate, Policy and Consultation Branch, Department of Health: The important distinction is that it is only physician and hospital services. The act does list all the in-patient and out-patient hospital services that must be insured on uniform terms and conditions. With respect to physician services, as Ms Hoffman has described, it is mostly by negotiation between the provinces and the medical professions.

That has led to a very comprehensive list that is ever-changing as new technologies and physician services become available. It has been found to be very advantageous to not have a list, because it becomes out of date and it is always more difficult to add or remove something. It is therefore left up to negotiation, and then the physician determines when it is medically necessary. Cosmetic surgery is often used as an example of a service that can be both medically necessary and medically unnecessary. If you are in a car accident and are disfigured, it could become medically necessary to repair your disfigurement through cosmetic surgery. However, if you choose to have your nose shortened or lengthened, that would not be a medically necessary service and would not be insured.

Senator Robertson: Let me be perhaps both more general and more specific, if that is possible.

One of the problems that provinces are having right now is that hospital stays are often shortened and then the patient is sent home. Most provinces do not cover the care taking place in the home. Nursing homes and special care homes are under different

de les analyser sans avoir un peu de temps à sa disposition. J'espère qu'après que nous aurons eu la chance d'en prendre connaissance, nous aurons une autre occasion de vous poser des questions. Pour être honnête, on ne peut pas faire d'observations réfléchies sur un texte que l'on reçoit cinq minutes avant le début de la séance.

Madame Hoffman, je vais commencer par le commencement. Ce qui m'a intéressée le plus dans votre exposé, c'est le principe de l'intégralité. Je sais que vous n'avez pas pu vous y attarder. À l'échelle nationale, pourriez-vous me dire quels soins de santé sont couverts par l'assurance-maladie? Qu'est-ce qui est visé par le principe de l'intégralité? Je vous demanderais de le répéter pour moi.

Mme Hoffman: Je pourrais peut-être revenir brièvement sur ce que j'ai dit, puis je demanderai à M. Fedyk, directeur intérimaire de la division responsable, de vous donner plus de précisions.

En résumé, en vertu des critères de l'intégralité de la LCS, les régimes provinciaux et territoriaux d'assurance-maladie doivent assurer tous les services de santé médicalement nécessaires fournis par les hôpitaux, les médecins ou les dentistes, aux personnes admissibles de la province ou du territoire. J'ai ajouté que la nécessité médicale n'est pas définie dans la loi et que c'est une question qui fait l'objet de négociations et qui peut susciter des divergences d'une province à l'autre.

M. Frank Fedyk, directeur intérimaire, Division conformité à la Loi canadienne sur la santé, Direction des affaires intergouvernementales, Direction générale des politiques et de la consultation, ministère de la Santé: La distinction importante ici, c'est qu'il ne s'agit que des services fournis par les hôpitaux et les médecins. La loi énumère tous les services internes et externes qui doivent être assurés en vertu de conditions uniformes. En ce qui concerne les services fournis par les médecins, comme Mme Hoffman l'a dit, ceux-ci font surtout l'objet de négociations entre les provinces et la profession médicale.

Cela a abouti à une liste très complète en constante mutation, au fur et à mesure que de nouvelles technologies ou services médicaux peuvent être utilisés. On a constaté qu'il était très avantageux de ne pas avoir de liste parce qu'elle devient périmée et qu'il est toujours difficile d'ajouter ou d'enlever quelque chose. Cela est donc laissé à la négociation, après quoi le médecin décide ce qui est médicalement nécessaire. La chirurgie esthétique est souvent donnée comme exemple de service qui peut être à la fois médicalement nécessaire et médicalement injustifié. Si vous êtes victime d'un accident de la route et que vous êtes défiguré, il pourra devenir médicalement nécessaire de remédier à votre défigurement à l'aide de chirurgie esthétique. Si, par contre, vous décidez de vous faire raccourcir ou rallonger le nez, il ne s'agit pas d'un service médicalement nécessaire, et celui-ci n'est donc pas assuré.

Le sénateur Robertson: J'aimerais être à la fois plus général et plus précis, si c'est possible.

Un des problèmes auxquels font face les provinces actuellement, c'est que les séjours à l'hôpital sont souvent abrégés et que le malade est renvoyé chez lui. La plupart des provinces ne couvrent pas les soins donnés à domicile. Les foyers de soins

classifications. If you did not have this comprehensive list, what would you define as health care?

What concerns me is that the current definition of health care is so obsolete, much is being lost. Have the ministers discussed this? They surely must be trying to make a determination of what is health care in today's structure. We seem very out of date on this. We are leaving it up to the provinces, but many, like my own, are financially strapped. Where do they get the money for these things they still have to deliver? I believe that is where much of the problem lies, in addition to the waiting lists for hospital care and special invasive procedures. The public is becoming extremely upset because they get dumped out of the hospital and the provinces have no money to care for them.

What is your definition of health care in a perfect world, just forgetting for a moment this comprehensiveness?

Mr. Fedyk: The care that Canadians require is physician, hospital, and home care. It is a full spectrum. Many provinces do have home and community care programs, but they are very much a patchwork. The legislation under which the federal government makes a contribution covers the physician and hospital services, and part of our extended health care contribution is for nursing homes, adult residential care, and a component of home and community care. However, the amount was \$20 per capita in 1977. With the amalgamation under the Canada Health Act in 1984, the criteria relating to adult residential care and the health care component of home care were only subject to the conditions of the act that refer to recognition and the provision of information.

Mr. Fedyk: I think we would all agree that it is quite comprehensive and includes care in the community.

Senator Robertson: There is absolutely no way that the provinces can look after all that under the present financial circumstances. That is another issue.

When did the new formula that replaced the CHST come into force?

Ms Hoffman: When did the CHST come in?

Senator Robertson: I understand it was phased out.

Ms Hoffman: Are you talking about the move to equal per capita under CHST?

Senator Robertson: Yes.

Ms Hoffman: That was announced in the 1999 budget.

Senator Robertson: It is my personal opinion that "per capita" is terribly unfair and I do not know why the provinces, especially the smaller ones, would ever agree to that. It is necessary to have a certain amount of money to develop a decent base before the implementation of such a system can be accomplished. If there are more people, there will be a greater opportunity to develop a better base. Without that better base, a province will be in trouble right from the start. We will discuss that subject.

infirmiers et de soins spéciaux figurent dans des catégories différentes. Si vous n'aviez pas cette liste complète, qu'est-ce que vous définiriez comme soins de santé?

Ce qui me préoccupe, c'est que la définition actuelle des soins de santé est à ce point dépassée, que beaucoup sont exclus. Les ministres en ont-ils discuté? Ils doivent sûrement essayer de décider ce que sont les soins de santé dans la structure d'aujourd'hui. Nous semblons être bien en retard sur ce point. Nous en laissons la responsabilité aux provinces, mais beaucoup, comme la mienne, manquent de fonds. Où trouveront-elles l'argent pour fournir les services nécessaires? Pour moi, c'est là que se situe l'essentiel du problème, en plus des listes d'attente pour les soins hospitaliers et les méthodes invasives spéciales. Les citoyens sont furieux parce qu'on les expulse de l'hôpital et que les provinces n'ont pas d'argent pour s'occuper d'eux.

Quelle est votre définition idéale des soins de santé, si l'on oublie un instant cette intégralité?

M. Fedyk: Les soins dont les citoyens ont besoin sont les soins fournis par le médecin ou l'hôpital et les soins à domicile. Cela couvre tout. Beaucoup de provinces ont des programmes de soins à domicile ou de proximité, mais c'est très inégal. La loi en vertu de laquelle le gouvernement fédéral verse une contribution financière, englobe les services fournis par le médecin et l'hôpital, et une partie de notre contribution sert aux services complémentaires de santé va aux foyers de soins infirmiers, aux soins en résidence pour adultes et à certains soins à domicile et de proximité. Toutefois, le montant était de 20 \$ par habitant en 1977. Après le regroupement en vertu de la Loi canadienne sur la santé en 1984, les critères relatifs aux soins en résidence pour adultes et le volet soins de santé des soins à domicile, étaient assujettis uniquement aux conditions de la loi portant sur la reconnaissance et la communication de renseignements.

M. Fedyk: Nous conviendrons tous, je pense, que cela englobe beaucoup de choses et comprend les soins de proximité.

Le sénateur Robertson: Il est tout à fait impossible pour les provinces de s'occuper de tout cela dans la situation financière actuelle. C'est une autre question.

À quel moment est entrée en vigueur la nouvelle formule, celle qui a remplacé le TCSPS?

Mme Hoffman: À quel moment le TCSPS a-t-il été instauré?

Le sénateur Robertson: Je crois comprendre qu'on l'a éliminé.

Mme Hoffman: Parlez-vous du passage au transfert égal par habitant en vertu du TCSPS?

Le sénateur Robertson: Oui.

Mme Hoffman: On l'a annoncé dans le budget de 1999.

Le sénateur Robertson: À mon avis, le calcul par habitant est foncièrement injuste et je ne comprends pas pourquoi les provinces, surtout les plus petites, seraient prêtes à y consentir. Il faut une certaine somme pour se doter d'une base minimale avant de pouvoir instaurer un système comme celui-là. Si la population est plus nombreuse, il sera plus facile de se doter d'une meilleure base. Sans cette base, la province sera en difficulté dès le début. Nous allons discuter de ce sujet.

[Translation]

Senator Gill: I presume that you have statistics regarding Aboriginal people. Was there an increase in the budgets for the past 5 or 10 years? Is it more expensive to treat an Aboriginal than a non-Aboriginal?

[English]

Ms Hoffman: I can respond briefly to those questions, although I think that it might be more helpful if we ask individuals in the Medical Services Branch of Health Canada to provide the committee with more detailed information.

Yes, there have been budgetary increases for health services for First Nations and Inuit that are financed by the federal government. Some of those budgets have been subject to caps, but it is rather complicated because First Nations, Inuit, and aboriginal people living off reserve do receive services from various sources. They may receive services that are directly or indirectly financed by the federal government. As citizens of Canada, they also receive services at the provincial and community level.

You asked if it was more expensive to provide services to aboriginals than to non-aboriginal Canadians. Yes, but probably for two main reasons. One is the regional dispersal of the aboriginal population. Providing services in remote areas is extremely difficult of course. Those costs, for example the cost of transportation itself, are enormous. As we all know, regrettably, the standard of health of the aboriginal population is, on average, considerably poorer than that of non-aboriginal Canadians, and that includes their vulnerability to a number of quite debilitating chronic diseases. I am thinking, for example, of diabetes. I would be happy to have the department respond in more detail to your questions.

Senator Gill: I would like to know if the condition of the aboriginal people is improving or not. I am hearing that a lot of money is being invested in that area and the problem is still the same or maybe even greater.

Ms Hoffman: The health status of aboriginal people relative to the non-aboriginal population is improving on average. The disparities are significant and they persist. There is no question that there is still a great deal to achieve. There is also no question that some significant improvements have been accomplished.

Senator Carstairs: The National Forum on Health has recommended a national pharmacare program, as have others. Your own study shows it to be the fastest growing area of health care costs. What work is being done in the Department of Health to develop a strategy with respect to pharmacare in this country?

Ms Hoffman: We have been dealing for some time with the provinces on a whole array of pharmaceutical issues, not necessarily exclusively focused on pharmacare, but on other issues that concern improvements to access and the cost constraints. Access to drugs is certainly on the agenda of the federal, provincial, and territorial ministers. That work will proceed as the ministers agree that that subject should be one of the priority areas of concern.

[Français]

Le sénateur Gill: Je présume que vous avez des statistiques concernant les autochtones. Y a-t-il eu une augmentation des budgets durant les 5 ou 10 dernières années? Coûte-t-il plus cher de soigner un autochtone qu'un non-autochtone?

[Traduction]

Mme Hoffman: Je peux brièvement répondre à ces questions, quoiqu'il serait plus utile de demander aux représentants de la Direction générale des services médicaux de Santé Canada de donner plus de précision au comité.

Oui, il y a eu des augmentations de budgets pour les services de santé, à l'intention des Premières nations et des Inuits, financés par le gouvernement fédéral. Certains de ces budgets ont été plafonnés, mais c'est assez compliqué parce que les Premières nations, les Inuits et les autochtones qui vivent hors réserve reçoivent des services de sources diverses. Ils peuvent recevoir des services directement ou indirectement financés par le gouvernement fédéral. Comme citoyens du pays, ils reçoivent aussi des services dans leur province et leur localité.

Vous avez demandé s'il est plus coûteux de fournir des services aux autochtones qu'aux non-autochtones du Canada. Oui, sans doute pour deux raisons. La première est la dispersion régionale de la population autochtone. Il est évidemment très difficile de fournir des services dans les régions éloignées. Les coûts, de transport par exemple, sont énormes. Comme nous le savons tous, malheureusement, le niveau de santé de la population autochtone est en moyenne très inférieur à celui des Canadiens non autochtones, ce qui comprend une vulnérabilité à un certain nombre de maladies chroniques très débilitantes, comme le diabète. Je serais heureuse de demander au ministère de répondre à vos questions avec plus de précision.

Le sénateur Gill: J'aimerais savoir si l'état de santé des Autochtones s'améliore ou non. J'entends dire que beaucoup d'argent est investi dans ce secteur mais que le problème reste le même ou s'aggrave peut-être.

Mme Hoffman: En moyenne, l'état de santé des populations autochtones, par rapport au reste de la population, est en train de s'améliorer. Les disparités sont importantes et continuent d'exister. Il ne fait pas de doute qu'il reste beaucoup à faire. Il est certain aussi que des améliorations importantes ont été réalisées.

Le sénateur Carstairs: Comme d'autres, le Forum national sur la santé a recommandé la création d'un régime national d'assurance-médicaments. Votre propre étude montre que c'est le secteur de la santé où les coûts augmentent plus rapidement. Que fait le ministère de la Santé pour élaborer une stratégie d'assurance-médicaments au Canada?

Mme Hoffman: Nous traitons, depuis quelque temps déjà, avec les provinces de tout un ensemble de questions pharmaceutiques, qui ne portent pas exclusivement sur l'assurance-médicaments mais visent plutôt à faciliter l'accès et à alléger les contraintes financières. L'accès aux médicaments figure bien au programme de travail des ministres fédéral, provinciaux et territoriaux. Ces travaux progresseront lorsque les ministres conviendront qu'il s'agit d'un sujet prioritaire.

Senator Carstairs: In other words, not very much has taken place since the National Forum on Health reported on the need for a national pharmacare program.

My next question has to do with the fact that anecdotally, and then more specifically with respect to my own province, hospitals have as many as 40 per cent of their beds occupied by individuals who could be in long-term care beds, personal care homes, or indeed in the community if that were possible. We have examples of people waiting for acute care beds, not because there are not enough, but because they are being used for other things.

What kind of strategy do we have, if any, to increase extended care beds or build a home care program that would free significant numbers of acute care beds for acute care?

Ms Hoffman: I will make this comment in respect of your earlier question about pharmacare. Through programs such as the Health Transition Fund, a lot of excellent and extensive work — innovative pilot projects of quite considerable scope and expense — has been conducted in the areas of improved access to pharmaceuticals and to home care. Those were two of the highest priority areas flowing from the National Forum on Health and an agreed set of priorities from the provinces, territories, and the federal government. A great deal of work has been done to develop what are believed to be effective models that address the kind of issues that you have identified.

However, clearly the decision on whether or not there will be a national approach to pharmacare or home care service provision will ultimately be taken by ministers collaboratively. At the same time, our knowledge about what models might work and how effective and efficient they might be has greatly increased.

I might point out also that we know that through the 1990s it was possible to reduce per capita spending on hospital care by doing exactly as you have suggested needs to be done. Individuals who needed extended or chronic care, whether home or institutional, but of a sort that was considerably less expensive than hospital acute care, were able to be relocated to other facilities in home or community environments for their recuperation. Clearly, this has not been done to a sufficient degree.

Senator Carstairs: Is it possible for this committee to see some of the studies that have been conducted and the results of some of these pilot projects, both with respect to pharmacare and the delivery of home care?

Ms Hoffman: Absolutely. I am sure that individuals connected with the Health Transition Fund would be happy to come and talk about their work and the reports received so far. There are a great many more that we anticipate receiving over the next one year to 15 months.

Senator Carstairs: My final question has to do with the fact that a number of witnesses who have appeared so far have indicated that the most cost-effective spending in the entire health care system is on illness prevention. Prevention programs are not covered under the “umbrella,” if you will, of comprehensiveness because there has always been a “sweep it under the rug” attitude

Le sénateur Carstairs: Il ne s'est pas fait grand-chose depuis que le Forum national sur la santé a réclamé un programme national d'assurance-médicaments.

Ma question suivante porte sur le fait qu'en général, et plus particulièrement dans ma province, 40 p. 100 des lits d'hôpitaux sont occupés par des malades qui pourraient être dans des lits de soins de longue durée, dans des foyers de soins personnels, ou même chez eux si c'était possible. Nous connaissons des exemples de gens qui attendent un lit pour soins intensifs, non pas parce qu'ils existent en nombre insuffisant, mais parce qu'ils servent à d'autres fins.

Quelle stratégie avons-nous pour augmenter le nombre de lits de soins prolongés ou pour mettre en place un programme de soins à domicile qui libérerait un nombre important de places de soins intensifs pour ceux qui en ont besoin?

Mme Hoffman: Je vais dire ceci en réponse à votre question concernant l'assurance-médicaments. Grâce à des programmes comme le Fonds pour l'adaptation des services de santé, une grande quantité d'excellent travail — des projets pilotes novateurs coûteux et à grande échelle — a été réalisé dans le domaine de l'amélioration de l'accès aux produits pharmaceutiques et aux soins à domicile. Il s'agissait là des deux domaines prioritaires cernés par le Forum national sur la santé et acceptés par les provinces, les territoires et le gouvernement fédéral. Beaucoup de travail a été fait pour créer ce que nous croyons être des modèles efficaces de solutions aux problèmes que vous avez relevés.

Toutefois, il est clair que la décision concernant l'adoption d'une formule nationale d'assurance-médicaments ou de soins à domicile sera prise en définitive par l'ensemble des ministres. Toutefois, nous en savons beaucoup plus sur les modèles qui pourraient être efficaces et sur leur efficacité.

Nous savons également que tout au long des années 90, nous avons pu réduire les dépenses par habitant pour les soins hospitaliers en faisant précisément ce que vous avez suggéré. Les malades qui avaient besoin de soins prolongés — les malades chroniques —, soit à domicile ou en établissement, mais d'un type beaucoup moins coûteux que les soins intensifs en établissement hospitalier, ont pu être placés dans d'autres installations à domicile ou dans leur localité pour se rétablir. Il est évident qu'on ne l'a pas assez fait.

Le sénateur Carstairs: Le comité pourrait-il voir certaines des études réalisées et les résultats de certains de ces projets pilotes en ce qui concerne l'assurance-médicaments et les soins à domicile?

Mme Hoffman: Tout à fait. Je suis certaine que le personnel du Fonds pour l'adaptation des services de santé se fera un plaisir de venir vous parler de son travail et des rapports qu'il a reçus jusqu'à ce jour. Nous nous attendons à en recevoir beaucoup plus dans les 12 à 15 prochains mois.

Le sénateur Carstairs: Ma dernière question porte sur le fait qu'un certain nombre de témoins qui ont comparu jusqu'ici ont déclaré que les dépenses les plus efficaces dans le système de santé sont celles axées sur la prévention. Les programmes de prévention ne sont pas couverts par le principe de l'intégralité parce que, en ma qualité de politicienne provinciale, j'ai constaté

in my experience as a provincial politician. Provincial politicians cannot prove that preventive medicine works. Thus, there is great reluctance to put any dollars into preventive medicine because while there are people knocking on the hospital doors, you have to spend all the money there. The story is never about the study that showed that a prevention model worked. The story is about the 35 people lined up in an emergency room waiting for a bed in the acute care section of the hospital.

We know about that dynamic. What initiatives is the federal government taking to provide funding for preventive medicine?

Ms Hoffman: I would say we are pursuing that very broadly on two tracks. As you no doubt know, we pursue many risk factor reduction or disease prevention strategies. I mentioned heart health, HIV, AIDS, and anti-smoking campaigns in my opening remarks. Those clearly have very large preventive components. That is one track. The other is the priority that we want to place on primary care reform.

We think that a new approach to the interaction of physicians with patients is absolutely critical to getting prevention considered seriously within the health care system. Some changes in the way primary care is delivered will certainly be necessary, and in what is considered to be significant and should be financed.

Some elements of preventive care are "billable," but many, such as advice giving and counselling of patients and so on, are not. That is not to say that physicians do not do it, but it does not have the priority that I think all of us would want, and in the way previous witnesses have spoken about. It does not have a place of prominence, either in the interaction of physicians with individuals or their interaction with whole populations in their respective communities.

We agree absolutely on the priority, and are working on those two tracks. The first one, disease prevention, is a major national strategy. It has been part of Health Canada's activity for quite some time.

Senator Carstairs: Perhaps this is not a fair question to ask a bureaucrat, but I am going to put it to you and answer it if you can. Why, therefore, do we not even spend the dollars that are available for anti-smoking programs? The monies are there. They are collected for that purpose, but we do not spend them.

Ms Hoffman: You suggested it was not a fair question for a bureaucrat and I will concur.

Senator Carstairs: Fair enough.

Senator Callbeck: I want to ask a couple of questions about the formula for CHST, which is made up of cash plus the tax points. What is the formula for determining the amount of cash?

Ms Hoffman: I will ask Mr. Halliwell to respond to that, please.

Mr. Cliff Halliwell, Director General, Applied Research and Analysis Directorate, Health Canada: There is no current formula for determining the cash portion. The CHST level is set

une attitude de «balayer moi ça sous le tapis». Les politiciens provinciaux ne peuvent pas prouver l'efficacité de la médecine préventive. On hésite donc beaucoup à y consacrer des fonds parce que, tant que les malades frapperont aux portes des hôpitaux, c'est là qu'il faut mettre tout l'argent. On ne parle jamais des études qui montrent que la prévention a été efficace. On parle plutôt des 35 personnes qui font la queue à la salle d'urgence pour obtenir un lit aux soins intensifs.

C'est un phénomène que nous connaissons. Quelles initiatives le gouvernement prend-il pour financer la médecine préventive?

Mme Hoffman: Notre action suit deux grands axes. Comme vous le savez sans doute, nous appliquons de nombreuses stratégies de réduction du risque ou de prévention de la maladie. J'ai parlé des maladies cardiaques, du VIH, du sida, des campagnes anti-tabagisme dans ma déclaration liminaire. Dans tous les cas, il y a un large volet de prévention. C'est un des axes. L'autre, c'est la priorité que nous voulons accorder à la réforme des soins primaires.

À notre avis, une nouvelle conception de l'interaction médecin — patient est absolument essentielle, si l'on veut que la prévention occupe la place qu'elle mérite dans le régime de santé. Il faudra absolument apporter certains changements à la prestation des soins primaires, et aux domaines que l'on juge importants et qui doivent être financés.

Certains éléments des soins préventifs sont facturables, mais beaucoup comme, par exemple, les conseils aux patients ou les services de counselling ne le sont pas. Ce qui ne veut pas dire que les médecins ne prodiguent pas ces conseils, mais ce domaine n'a pas la priorité que nous voulons tous lui accorder, à mon avis, et ce, dans le sens où les témoins précédents en ont parlé. Cela n'occupe pas une place importante, qu'il s'agisse de l'interaction médecin — patient ou de l'interaction avec le grand public.

Nous sommes tout à fait d'accord avec cette priorité, et nos efforts portent sur ces deux axes. La premier, soit la prévention des maladies, est une grande stratégie nationale. Elle fait partie des activités de Santé Canada depuis un bon bout de temps déjà.

Le sénateur Carstairs: Il n'est peut-être pas juste de poser une telle question à un fonctionnaire, mais je vais vous la poser quand même, et vous y répondrez si vous pouvez. Pourquoi, par conséquent, ne dépensons-nous même pas les crédits que nous avons pour les programmes anti-tabagisme? L'argent est là. Il a été perçu à cette fin, mais nous ne le dépensons pas.

Mme Hoffman: Vous avez dit qu'il n'était pas juste de poser une telle question à un fonctionnaire, et je suis d'accord.

Le sénateur Carstairs: Comme vous voudrez.

Le sénateur Callbeck: Je veux poser quelques questions au sujet de la formule du TCSPS, qui se compose de versements en espèces et de points d'impôt. Quelle formule emploie-t-on pour déterminer le montant en espèces?

Mme Hoffman: Je vais demander à M. Halliwell de répondre à cette question, si vous le permettez.

M. Cliff Halliwell, directeur général, Direction de la recherche appliquée et de l'analyse, Santé Canada: Il n'existe pas actuellement de formule pour établir la partie en espèces. Le

by budgetary decision of the Government of Canada. I believe that in the 1999 budget, the federal government committed to establishing a longer planning horizon for the level of the CHST that it provides to the provinces. Under the Social Union Framework Agreement, the federal government has also agreed to give notice of changes in the level of the CHST cash entitlement. However, there is no formula driving the level of the CHST.

In the past two budgets of 1999 and 2000, prudent fiscal planning left the federal government with a budgetary surplus that exceeded the commitment to pay down debt. The "surplus surplus," if you will, was put into a trust fund to help the provinces meet their health care needs in 1999, and health care and education needs in 2000. This was a mechanism by which "surplus surplus" was made available to help provinces over subsequent periods, four years in the case of the 1999 entitlement. Budgetary resources from the federal government for fiscal year 1998-1999 were put into a trust fund from which the provinces were able to draw at a pace that they thought appropriate. The same thing was done with the \$2.5 billion in budget year 2000. There is no formula that drives the cash portion.

Senator Callbeck: You say that the decision is made every year in the budget, except for these trust amounts that have been set up. Thus a province must wait until the budget comes down before they really know how much they will get?

Mr. Halliwell: The provinces know what core funding they will receive under the CHST over the next several years. What they did not know, particularly at the time of the 1999 budget, was that they would be getting a one-time — it then turned out to be twice one time — transfer under the CHST.

Nonetheless, the provisions that were made gave them flexibility and a way to avoid being in a rush to spend those funds, the value of which was unknown until the Minister of Finance released his budget publicly. They do have the option then of planning as to at what pace to draw down that trust fund. Therefore, they have a degree of certainty there.

They know the minimum they are going to get, but the last two budgets have given them more than that. They do not know, nor can they be told, whether there will be another increase in a subsequent period, which again would be a policy decision at budget time.

Senator Callbeck: You are saying that before the budget comes down, they know there is a minimum amount of core funding that they will receive. How do they know that? There is obviously some kind of formula. How is that determined, and how far ahead does a province know?

niveau du TCSPS est fonction du budget du gouvernement du Canada. Je crois que dans le budget de 1999, le gouvernement fédéral s'est engagé à établir un horizon de planification à plus long terme pour les transferts aux provinces. En vertu de l'Entente-cadre sur l'union sociale, le gouvernement fédéral a également accepté de donner un préavis aux provinces s'il modifie les montants versés en vertu du TCSPS, auxquels elles ont droit. Cependant, il n'existe pas de formule permettant de déterminer le niveau de financement du TCSPS.

Lors des deux derniers budgets, ceux de 1999 et 2000, le gouvernement fédéral, grâce à une planification financière prudente, s'est retrouvé avec un excédent budgétaire qui dépassait l'engagement qu'il avait pris relativement au remboursement de la dette. Cette «excédent de l'excédent», si vous voulez, a été versé dans un fond de fiducie qui doit aider les provinces à satisfaire leurs besoins en matière de santé en 1999, et leurs besoins en matière de santé et d'éducation en 2000. C'est grâce à ce mécanisme que «l'excédent de l'excédent» nous permettra d'aider les provinces pendant les années subséquentes, quatre ans dans le cas des montants de 1999 auxquels elles ont droit. Les ressources budgétaires du gouvernement fédéral pour l'année financière 1998-1999 ont été versées dans un fonds de fiducie d'où les provinces peuvent retirer des montants au rythme qu'elles jugent approprié. On a fait la même chose avec les 2,5 milliards de dollars du budget de l'an 2000. Mais il n'y a pas de formule qui dicte le niveau des montants en espèces.

Le sénateur Callbeck: Vous dites que la décision est prise chaque année dans le cadre du budget, sauf pour ces montants versés dans les fonds de fiducie qui ont été créés. Ainsi une province doit attendre le dépôt du budget fédéral avant de vraiment savoir combien elle touchera.

M. Halliwell: Les provinces savent à quel financement de base elles ont droit en vertu du TCSPS au cours des quelques prochaines années à venir. Ce qu'elles ne savaient pas, particulièrement au moment où le budget de 1999 a été déposé, c'était le montant des transferts ponctuels dans le cadre du Transfert — et il s'est avéré qu'il y en a eu deux.

Néanmoins, on a pris des mesures pour leur donner une certaine marge de manoeuvre et d'éviter qu'elles ne s'empressent à dépenser ces fonds dont les montants étaient inconnus avant que le ministre des Finances ne dépose son budget. Elles peuvent alors planifier les ponctions qu'elles vont opérer dans ce fonds de fiducie. Elles ont donc une certaine certitude de ce côté-là.

Elles savent le minimum qu'elles vont toucher, mais les deux derniers budgets leur ont donné plus que cela. Elles ne savent pas, et on ne peut pas le leur dire non plus, s'il y aura une autre augmentation plus tard, et cela relèverait encore une fois d'une décision gouvernementale au moment du budget.

Le sénateur Callbeck: Vous dites qu'avant le dépôt du budget, elles savent qu'il y a un montant minimum du financement de base qu'elles recevront. Comment le savent-elles? Il existe de toute évidence une formule quelconque. Comment est-ce déterminé, et combien de temps à l'avance la province connaît-elle ce montant?

Mr. Halliwell: The federal budget sets out a multi-year track for the level of the Canada Health and Social Transfer to the provinces.

Senator Callbeck: For the core funding?

Mr. Halliwell: Yes.

Senator Callbeck: Thus, they would know for a number of years.

Mr. Halliwell: Which is the vast bulk of the CHST cash transfer, I might add.

Senator Callbeck: How far ahead would they know about that core funding?

Mr. Halliwell: Four years.

[Translation]

Senator Pépin: I also sit on another committee. Depending on the province, often some treatments or services seem more difficult to access than others. The distribution of resources and expenditures for health care seem to vary from one province to the next.

How do the health care expenditures of a province compare to those of another province? Can higher expenditures be explained by higher salaries in wealthier provinces? Are the wealthier provinces more inclined to spend more per capita on health care than poorer provinces? Do the richer provinces have a healthier population? Are the expenditures of the province linked to the health care needs of the population? Do the provinces with a lower socio-economic status or with a more aged population spend more money per capita?

The follow-up subcommittee to update "Of Life and Death," which examines palliative care, has received various opinions about this. When we were discussing health care services in general, we were wondering whether we would find some answers on this subject.

[English]

Ms Hoffman: Perhaps I could ask Mr. Halliwell to respond first on the variability in spending between provinces, and then I will pick up on some of your other points.

[Translation]

Mr. Halliwell: I would like to point out that when we discuss a province's capacity to provide health care services, we must not forget equalization payments. We have programs that helped the have-not provinces provide all necessary services to their citizens.

We must not forget that. These funds are not available for the three wealthiest provinces in Canada. However, some provinces receive many different forms of revenue from the federal government. Often, when the role of the federal government in the health care system is discussed, equalization payments tend to be forgotten.

M. Halliwell: Le budget fédéral établit un barème pluriannuel pour le niveau du Transfert canadien en matière de santé et de programmes sociaux pour les provinces.

Le sénateur Callbeck: Pour le financement de base?

M. Halliwell: Oui.

Le sénateur Callbeck: Elles savent donc combien elles toucheront pour un certain nombre d'années.

M. Halliwell: J'ajoute que cela constitue le gros du transfert en espèces aux termes du TCSPS.

Le sénateur Callbeck: Combien de temps à l'avance connaissent-elles le niveau de ce financement de base?

M. Halliwell: Quatre ans.

[Français]

Le sénateur Pépin: Je siège à un autre comité également. Selon la province, souvent certains soins ou services semblent plus difficiles d'accès que d'autres. Les répartitions des ressources et des dépenses pour les soins de santé semblent varier d'une province à l'autre.

Comment les dépenses des soins de santé d'une province se comparent-elles vis-à-vis d'une autre province? Les dépenses plus élevées s'expliquent-elles par des salaires plus élevés dans les provinces plus riches? Les provinces riches se montrent-elles inclinées à dépenser davantage par habitant en soins de santé que les provinces plus pauvres? Est-ce que les provinces plus riches ont une population plus en santé? Les dépenses des provinces sont-elles liées aux besoins de santé de sa population? Les provinces où la situation socio-économique est plus faible et où les personnes sont plus âgées dépensent-elles plus d'argent par habitant?

Le sous-comité de mise à jour «De la vie et de la mort», en ce qui a trait aux soins palliatifs, a reçu certaines variantes. Lorsqu'on parlait du service de santé en général, on se demandait si sur ce sujet on pouvait trouver certaines réponses.

[Traduction]

Mme Hoffman: Je pourrais peut-être demander à M. Halliwell de répondre d'abord à la question sur les différences qu'il y a dans les dépenses entre les provinces, et après je répondrai à certains autres éléments de votre question.

[Français]

M. Halliwell: J'aimerais vous faire remarquer que lorsqu'on discute de la capacité d'une province à donner des services de santé, il ne faut pas oublier la péréquation. Nous avons des programmes qui aident les provinces moins nanties pour donner tous les services nécessaires à leurs citoyens.

Il ne faut pas l'oublier. Ces fonds ne sont pas disponibles pour les trois provinces les plus riches au Canada. Cependant, certaines provinces reçoivent de nombreux revenus du gouvernement fédéral. Souvent lorsqu'on discute du rôle du gouvernement fédéral dans le système de santé, on oublie la péréquation.

On pages 7, 8, 9 and 10 of our brief, two graphs compare health care expenditures in the public sector for all provinces. The first graph compares the level of public expenditures, the second compares the total level of expenditures, that is, public sector plus private expenditures.

Since we compared 1989 and 1999, we used data adjusted for inflation in order to be able to compare those two years which were 10 years apart. We observed that there was a significant increase in public spending in some provinces from 1989 to 1999.

In Newfoundland and Nova Scotia, in general, there was an increase in almost all provinces for real expenditures and that is per capita, to compare levels over those 10 years.

These graphs indicate that there is not much difference between the provinces in terms of spending. I cannot say this with certainty, but I believe that there is probably less variation in health care expenditures than in the GDP per capita. It is the role of our equalization payment system to enable the have-not provinces to offer comparable levels of service.

There may be more variation in private spending. It is not very obvious according to the graph on pages 9 and 10. Provinces where the citizens have the most disposable income can buy private health care services. But variations between the provinces are not very marked.

[English]

Ms Hoffman: I think the problem is that, first, we do not have a good overall estimate of the health status of entire populations in the country, or even within provinces, although we know a great deal. However, factors other than health status of the population, including particularly the efficiency of the system and decisions that provincial governments may have made about what additional services they will insure, will influence the overall level of expenditure. If you look at the variable of aging, you will not find a link between it and actual expenditure. It is nonetheless a major concern to try to establish what the relationship will be.

We know that the Canadian population as a whole will reach a point where 20 to 25 per cent of us will be over age 65 within approximately 40 years, but some provinces will reach that point in a little more than half that time. Although, for example, these provinces with faster rates of aging — Newfoundland, the Atlantic region generally, Saskatchewan — appear to have reasonably comparable levels of total spending now, there clearly is greater pressure in some of those provinces than in others. We do know now that the most important determinant of the level of spending is what the government in question decides to spend, not the health status of the population, its age profile, the dispersion of the population by region, and so on. Those are not ultimately the most important factors currently.

Aux pages 7, 8, 9 et 10 de notre mémoire, deux graphiques comparent les dépenses de la santé dans le secteur public pour toutes les provinces. Le premier graphique compare le niveau des dépenses publiques, le deuxième compare le niveau total des dépenses, soit le niveau public plus les dépenses privées.

Étant donné que nous avons comparé 1989 et 1999, nous avons utilisé des données ajustées pour les prix afin d'être capables de comparer ces deux années qui diffèrent de 10 ans. On constate qu'il y avait une augmentation assez importante dans les dépenses publiques dans certaines provinces de 1989 à 1999.

À Terre-Neuve et en Nouvelle-Écosse, en général, il y a eu une augmentation dans presque toutes les provinces dans les dépenses réelles et cela est per capita, pour comparer les niveaux pendant ces 10 ans.

Ces graphiques indiquent qu'il n'y a pas de très grandes différences entre les provinces dans les dépenses. Je ne peux pas dire avec certitude, mais je crois qu'il y a probablement moins de variation dans les dépenses de santé que dans le PIB per capita. C'est le rôle de notre système de péréquation de permettre aux provinces moins bien nanties d'offrir un niveau de service comparable.

Il y a peut-être un peu plus de variation dans les dépenses privées. Ce n'est pas très évident dans le graphique à la page 9 et 10. Les provinces dans lesquelles les citoyens ont plus de revenu disponible peuvent acheter plus de services de santé privés. Les variations entre les provinces ne sont pas très grandes.

[Traduction]

Mme Hoffman: À mon avis, le problème tient au fait, premièrement, que nous n'avons pas un bon aperçu général de l'état de santé de toutes les populations du pays, ou même des provinces, même si nous savons beaucoup de choses. Cependant, des facteurs autres que l'état de santé de la population, et cela comprend particulièrement l'efficacité du système et les décisions que les gouvernements provinciaux peuvent avoir prises relativement aux services supplémentaires qu'elles assureront, vous influencer le niveau général des dépenses. Prenez cette variable qu'est le vieillissement, vous n'avez pas à trouver de lien entre cette variable et la dépense réelle. Il est néanmoins très important d'établir ce que sera ce rapport.

Nous savons que l'ensemble de la population canadienne, d'ici à peu près 40 ans, atteindra un point où entre 20 et 25 p. 100 d'entre nous auront dépassé 65 ans, mais certaines provinces atteindront ce point dans un peu plus de 20 ans. Même si, par exemple, ces provinces où le vieillissement est plus rapide — Terre-Neuve, la région de l'Atlantique en général, la Saskatchewan — semblent avoir des niveaux raisonnablement comparables de dépenses maintenant, il est évident que certaines provinces seront mises à contribution davantage que d'autres. Nous savons avec certitude maintenant que l'élément le plus important dans la détermination du niveau de dépenses est le montant que chaque gouvernement décide de dépenser, et, non l'état de santé de la population, son profil d'âge, la répartition de la population selon les régions et ainsi de suite. À l'heure actuelle, ce ne sont pas là les facteurs les plus importants.

[Translation]

Senator Pépin: You talked about the fees that could be added when someone goes to the doctor. That doctor will receive medicare payments but will charge the patient 25 or \$50 according to the type of consultation. I did not know that that was becoming common practice. It is accepted in all provinces. Do we have a percentage? Someone told me that he had an eye examination. The doctor told him that he had always participated in medicare but charged him \$50 extra, above and beyond what medicare pays him. If someone says he cannot afford to pay \$50, can he go to another doctor?

[English]

Mr. Fedyk: Perhaps I could elaborate on the difference between insured and uninsured physician services. The visit to the medical physician is covered, while the visit to the optometrist is a supplementary benefit in terms of the Canada Health Act. Copayments and physician fees for such services are permitted, as with visits to chiropractors and physiotherapists outside of the hospital. The physician services are for medical and surgical appointments. Most provinces have de-insured visits to the optometrist, or they have limited coverage to various age groups. If you are under age 18 or over age 65, they cover the service. If you are between those two ages, it is then a supplemental insured service and there could be a copayment.

[Translation]

Senator Pépin: We talked about house calls. I come from Quebec. I remember a debate that took place perhaps a year or two ago regarding doctors who offered home care. We were told that medicare refuse to pay for those expenditures. Now we have sick people who receive palliative care and who are requesting visits from doctors. If I understand correctly, there is a group of doctors authorized to make house calls. Is this generally true throughout the country? Does it vary from one province to the other? Who is authorized to do this and who is not?

[English]

Mr. Fedyk: The palliative care programs across Canada are at different stages of development, similar to other home care services. Some are very well developed and include home visits by physicians, care nurses and other health professionals. Unfortunately, it does vary across the provinces and is not covered by the federal legislation. Therefore, there is a patchwork and there are no national standards.

[Translation]

Senator Pépin: Let us get back to our aging population. Increasingly, patients are being sent home 24 hours after surgery or even the same day. They may be asked to go to a CSLC. However, if you have patients who need a house call the day after surgery, be it gallbladder surgery or something else, can we then

[Français]

Le sénateur Pépin: Vous avez parlé des frais qui peuvent être ajoutés lorsque quelqu'un va faire une visite chez un médecin. Il reçoit l'assurance-maladie mais il va demander au patient de payer 25 ou 50 dollars selon la consultation. J'ignorais que cela devenait, de façon courante, une pratique. C'est accepté dans toutes les provinces. Est-ce qu'on a un pourcentage? Quelqu'un m'a dit qu'il s'était fait examiner la vue. Le médecin lui dit qu'il avait toujours fait partie de l'assurance-maladie mais il lui a demandé 50 dollars en surplus de ce que l'assurance-maladie donne. Si quelqu'un dit qu'il n'a pas les moyens de payer 50 dollars, peut-il aller consulter un autre médecin?

[Traduction]

M. Fedyk: Je peux peut-être vous parler un peu plus de la différence qu'il y a entre les services médicaux qui sont assurés et ceux qui ne le sont pas. En vertu de la Loi canadienne sur la santé, la visite chez le médecin est gratuite alors que celle chez l'optométriste ne l'est pas. Pour de tels services, on autorise le paiement d'une quote-part et d'honoraires médicaux, comme c'est le cas pour les visites chez le chiropraticien ou le physiothérapeute à l'extérieur de l'hôpital. Les services du médecin désignent les services médicaux et chirurgicaux. La plupart des provinces ont retranché de l'assurance-maladie les visites chez l'optométriste, ou ont limité le remboursement à divers groupes d'âge. Si vous avez moins de 18 ans ou plus de 65 ans, le service est gratuit. Si vous vous situez entre ces deux âges, il s'agit alors d'un service supplémentaire assuré et pour lequel on peut exiger une quote-part.

[Français]

Le sénateur Pépin: On a parlé des visites à domicile. Je viens du Québec. Je me rappelle d'un débat, il y a peut-être un an ou deux, au sujet des médecins qui offraient des services à domicile. On a dit que l'assurance-maladie refusait de payer ces dépenses. Maintenant on a des malades qui reçoivent des soins palliatifs qui réclament les visites des médecins. Si j'ai bien compris, il y a un groupe de médecins qui est autorisé à faire des visites à domicile. Est-ce général au pays? Est-ce variable d'une province à l'autre? Qui est autorisé et qui ne l'est pas?

[Traduction]

M. Fedyk: Les programmes de soins palliatifs au Canada franchissent diverses étapes de développement, comme c'est le cas des autres services de santé à domicile. Certains sont très avancés et comprennent des visites à domicile du médecin, de l'infirmière et d'autres professionnels de la santé. Malheureusement cette évolution varie en effet d'une province à l'autre, et ces programmes ne sont pas visés par la loi fédérale. Par conséquent, on se retrouve avec une mosaïque, et il n'existe pas de normes nationales.

[Français]

Le sénateur Pépin: Revenons à notre population vieillissante. De plus en plus, on retourne les malades chez eux 24 heures après une chirurgie ou la même journée. On va leur demander peut-être de se diriger vers les CLSC. Mais si vous avez des malades qui après une chirurgie ont besoin de visites à domicile le lendemain,

expect that such service will be provided to these people or will that choice be left up to the provinces?

[English]

Mr. Fedyk: The design, delivery and financing of health care services is primarily a provincial responsibility in determining what their health insurance programs will cover.

Senator Fairbairn: I am tempted to carry on with some of the questions that Senator Pépin has asked, particularly with respect to the variations in home care and the requirements of your position. Since there is a cost that many people cannot afford, the patient and the home care person will be missing out.

I would like clarification on another aspect of the issue.

I am from Alberta. We are engrossed, at the moment, in the controversial bill that is currently moving its way through the legislature. The federal government has questioned some parts of the bill, but seems to be waiting to see if the bill passes before making certain decisions.

I am aiming at the provisions of the Canada Health Act regarding user charges, extra billing, and consequent penalties that might be required. Can you explain how that works? For instance, in the Alberta bill, how would charges for enhanced services work? There was a hope that this would not be part of the proposed legislation, that it would be clearly prohibited, but it was not. It is a foggy area. How is it determined — by anecdotal reference? How is it determined what should be penalized? How is a penalty payment applied? That has been done in Alberta and elsewhere. Is that a population-based decision? How are the costs or charges for these enhanced services tracked? I suppose that extra billing is more clear-cut, but even so, could you explain that to me?

Mr. Fedyk: I would be more than pleased to. Enhanced goods and services are not subject to the criteria and conditions of the Canada Health Act, which covers insured physician and hospital services. The minister articulated his concern about enhanced medical goods or services provided in conjunction with an insured service, and stated that the Saskatchewan or the Ontario view was that those goods or services should be provided at no cost to the individual. That was what Minister Rock was articulating as the suggested approach.

Senator Fairbairn: It would be okay if enhanced services were provided at no extra cost.

Mr. Fedyk: At no extra cost. There could not then be a potential for queue-jumping in terms of access to that insured service through the purchase of an enhanced medical good or service. That is what the minister has articulated through his exchange of correspondence with Minister Johnson.

que ce soit pour la vésicule biliaire ou autre, est-ce qu'à ce moment on doit s'attendre à un service qui pourrait être donné à ces gens ou si ce sera laissé au choix des provinces?

[Traduction]

M. Fedyk: La conception, la prestation et le financement des services de santé constituent essentiellement une responsabilité de la province, et c'est elle qui établit les montants que son programme d'assurance-maladie remboursera.

Le sénateur Fairbairn: Je suis tentée de reprendre certaines questions que le sénateur Pépin a posées, surtout au sujet des différences dans les soins à domicile et de vos exigences. Étant donné qu'il y a là des dépenses que bien des gens ne peuvent pas se permettre, le patient et le fournisseur de soins à domicile seront exclus.

J'aimerais une précision sur un autre aspect de la question.

Je suis de l'Alberta. En ce moment, nous sommes plongés dans une controverse entourant un projet de loi qui est sur le point d'être adopté par l'assemblée législative provinciale. Le gouvernement fédéral a contesté certains aspects de ce projet de loi mais il semble attendre son adoption avant de prendre certaines décisions.

Ma question porte sur les dispositions de la Loi canadienne sur la santé concernant la participation aux frais, la surfacturation et les pénalités que l'on pourrait imposer en conséquence. Pouvez-vous nous expliquer comment cela fonctionne? Par exemple, en ce qui concerne le projet de loi de l'Alberta, comment établira-t-on les frais pour les services améliorés? On espérait que ces services ne seraient pas visés par ce projet de loi, qu'ils seraient formellement interdits, mais ce n'est pas le cas. On est dans le brouillard ici. Comment détermine-t-on qu'il y a eu infraction sur la foi d'un simple rapport? Comment détermine-t-on ce qui sera pénalisé? Comment va-t-on appliquer les pénalités financières? Cela a été fait en Alberta et ailleurs. S'agit-il d'une décision fondée sur des facteurs démographiques? Comment détermine-t-on les coûts ou les frais de ces services améliorés? J'imagine qu'il est plus facile de prouver qu'il y a eu surfacturation, mais même dans ce cas-là, pouvez-vous m'expliquer comment l'on procède?

M. Fedyk: Je serais plus qu'heureux de le faire. Les produits et services améliorés ne sont pas visés par les critères et conditions de la Loi canadienne sur la santé, laquelle englobe les services médicaux et hospitaliers assurés. Le ministre a exprimé ses réserves au sujet des produits ou services médicaux améliorés dans le cadre d'un service assuré, et il a dit que de l'avis de la Saskatchewan ou de l'Ontario, ces biens ou services devraient être fournis gratuitement à chaque citoyen. Telle est l'approche que le ministre Rock a proposée.

Le sénateur Fairbairn: On pourrait donc fournir ces services améliorés sans frais supplémentaires.

M. Fedyk: Sans frais supplémentaires. Pour ce qui est de l'accès à ces services assurés, personne ne pourrait resquiller en achetant un bien ou un service médical amélioré. C'est ce que le ministre a dit clairement dans son échange de lettres avec le ministre Johnson.

Our act covers the extra billing that occurs when physicians charge over and above the rate at which they are reimbursed by the province, or when an individual enters the hospital and there is a charge for medical goods or services. The act spells out the process.

Anyone can bring a complaint or a concern to the minister. It could be through a letter, a telephone call, or a study. The act specifies that we initiate an investigation with the province. The federal bureaucracy will ask the province for clarification and additional information. Once we are provided with that information, and have deemed that in fact this is a violation of one of the criteria, we usually find that it is a violation of the accessibility criterion.

The accessibility criterion states that you must provide access to a comprehensive range of insured health services, which are hospital and physician services, without any financial barrier. Financial barriers would be extra billing or user charges.

If we are satisfied with the determination that these are not legitimate charges, and that they are in fact extra billing, we then require them to provide further information on the amount charged. The legislation provides for an automatic dollar-for-dollar deduction. Thus, for extra billing amounting to \$1 million, we would reduce the transfer payment to that province by that amount.

If the information shows that these are legitimate charges, for example, enhanced goods and services for which the individual paid, we would not initiate a process.

The minister is required to consult with the province in question and must notify them through registered mail. They have 30 days to respond. When we receive the material, he must respond within 60 days on whether we accept their explanation or we will impose a penalty. The legislation is very specific about the way in which the bureaucracy and the minister approach their counterparts.

Senator Fairbairn: In the case of payment for enhanced services, do I understand that it becomes problematic in the context of where and how this is done? You say that if it is not insured, then there is no problem.

Mr. Fedyk: Enhanced medical goods and services are, by definition, over and above what is medically necessary. They are not insured and are beyond the scope of the act. They are non-insured services.

The concern arises when they are combined with an insured service.

Senator Fairbairn: That is what I am getting at.

Mr. Fedyk: I am not sure if I have answered the question, but there is no penalty that can be imposed through the Canada Health Act for the purchase of enhanced goods and services.

Senator Cohen: My question, probably to Mr. Halliwell, is regarding cost-sharing arrangements vis-à-vis block funding. What are the main advantages and disadvantages of the

Notre loi vise la surfacturation qui se produit lorsque le médecin demande plus que ce que la province lui rembourse, ou lorsqu'un particulier entre à l'hôpital et doit payer des frais pour les biens ou services médicaux. La loi énonce le processus qui s'applique alors.

Tout citoyen peut adresser une plainte au ministre ou lui faire part d'une préoccupation par lettre, appel téléphonique ou étude. La loi précise qu'une enquête est faite dans la province concernée. L'administration fédérale demandera des précisions et des informations supplémentaires à la province. Une fois que nous avons reçu ces informations, si l'on juge que l'on a contrevenu à l'un des critères, on constate habituellement que l'on a contrevenu au critère relatif à l'accès.

Le critère relatif à l'accès dit que la province doit assurer l'accès à une gamme complète de soins de santé assurés, lesquels comprennent les services hospitaliers et médicaux, sans le moindre obstacle financier. Les obstacles financiers sont la surfacturation ou la participation de l'utilisateur aux frais.

Si nous sommes convaincus que ce ne sont pas là des frais légitimes, qu'il y a bel et bien eu surfacturation, nous obligeons alors la province à nous fournir davantage d'information sur les frais qu'on a exigés. La loi prévoit une déduction automatique dollar pour dollar. Ainsi, si la surfacturation totalise un million de dollars, le paiement de transfert à cette province est réduit du même montant.

Si les informations démontrent qu'il s'agit de frais légitimes, par exemple, des produits et services améliorés que le particulier a acquittés, notre processus ne s'enclenche pas.

Le ministre a l'obligation de consulter la province en question et doit la notifier par courrier recommandé. La province a 30 jours pour répondre. Lorsque nous recevons sa réponse, le ministre doit répondre dans les 60 jours pour lui faire savoir si nous acceptons son explication ou si nous imposerons une pénalité. La loi est très explicite pour ce qui est de la façon dont l'administration et le ministre traitent avec leurs homologues.

Le sénateur Fairbairn: Dans le cas d'un paiement pour services améliorés, dois-je comprendre que cela pose problème selon le contexte où cela se fait et comment? Vous dites que si le service n'est pas assuré, alors il n'y a pas de problème.

M. Fedyk: Les produits et services médicaux améliorés dépassent, par définition, ce que l'on juge nécessaire sur le plan médical. Ces produits et services ne sont pas assurés et ne sont pas visés par la loi. Ce sont des services non assurés.

Le problème se pose lorsqu'ils sont conjugués avec un service assuré.

Le sénateur Fairbairn: C'est à cela que je veux en venir.

M. Fedyk: Je ne suis pas sûr d'avoir bien répondu à votre question, mais la Loi canadienne sur la santé ne prévoit aucune pénalité pour l'achat de produits et services améliorés.

Le sénateur Cohen: Ma question, qui s'adresse probablement à M. Halliwell, concerne les accords de partage des coûts comparativement au financement global. Quels sont les principaux

cost-sharing arrangement, and the strength and weaknesses of block funding? That is the first question.

Mr. Halliwell: Frankly, the disadvantage of a cost-sharing agreement is the simple fact that you end up with a situation where the people making spending decisions are spending 50-cent dollars. It is a lot easier to decide to spend money if somebody else is putting in half. That cost is then borne not by a particular province, but by all the citizens of Canada. At a time when the federal government was more concerned about its fiscal situation in the late 1970s — obviously less concerned subsequently — it was a disadvantage for the federal government to be exposed to spending-level decisions made by others.

The advantages of formula-based or block funding were a greater degree of certainty about the level of federal expenditures, and a greater incentive for cost control on the part of the people actually making the decisions.

One disadvantage of having transfers to the provinces, shall we say, tightly “partitioned off” into particular components — health separate from education, separate from social security — was that with the move to block funding, the particular circumstances of a province were not reflected. As Ms Hoffman has indicated, there is quite a difference in the age profile amongst the provinces. A province with a younger population would probably want to use CHST funds to a greater extent for education than a province with an older population and more need to spend it on health care. A system with a degree of flexibility offers those advantages.

In the end, the evolution of these transfers has been dominated by a move to reduce federal fiscal exposure to provincial decisions, in the hopes that that would lead to a greater incentive for cost control. It also gives the provinces greater flexibility to use those funds for the purposes that they see as most pressing, which will obviously reflect provincial variations in need, but also variations in preferences for the types of goods and services that the public sector should provide.

Senator Cohen: Do you think that the change has made the delivery of health care services more effective than it was?

Mr. Hoffman: That is a difficult question to answer. One further element that I might add to what has already been said is that the flexibility did not just extend to provincial decisions on apportioning money across sectors. It also pertained to how they would spend their money within health itself. One thing that did arise from that flexibility was a decision by most provinces to extend, under certain conditions, the range of insured services made available. One could argue that, given the total monies available over the decades concerned, provincially insured services with respect to drugs, home care, and various other health services might not have evolved if the 50/50 arrangement had continued.

avantages et inconvénients des accords sur le partage des coûts, et quels sont les points forts et les points faibles du financement global? C’est ma première question.

M. Halliwell: Franchement, l’inconvénient que présente un accord sur le partage des coûts tient au simple fait que l’on se retrouve dans une situation où les gens qui prennent les décisions relatives aux dépenses ne dépensent que la moitié du montant. Il est beaucoup plus facile de dépenser si quelqu’un d’autre en paie la moitié. Cette dépense est alors assumée non pas par une province en particulier, mais par tous les citoyens du Canada. À l’époque où le gouvernement fédéral avait davantage de difficultés budgétaires, à la fin des années 70 — difficultés qui se sont amoindries évidemment par la suite — le gouvernement fédéral était désavantagé du fait que les décisions relatives aux dépenses étaient prises par d’autres.

Le financement global, ou établi selon une formule, est avantageux dans la mesure où l’on a une plus grande certitude relativement au niveau des dépenses fédérales, et cela incite davantage les décideurs à limiter leurs coûts.

L’inconvénient que présentent les transferts aux provinces, rigoureusement «cloisonnés» — la santé distincte de l’éducation, et aussi de la sécurité sociale — c’est que, dans le passage au financement global, on ne tient pas compte des circonstances particulières d’une province. Comme Mme Hoffman l’a dit, au niveau du profil d’âge, il y a de grandes différences d’une province à l’autre. Une province dont la population est plus jeune voudra probablement consacrer une part plus grande des fonds du TCSPS à l’éducation, qu’une province dont la population est plus âgée, qui voudra consacrer plus d’argent à la santé. Un système souple offre de tels avantages.

Au bout du compte, l’évolution de ces transferts a été conditionnée par la décision du fédéral de se désengager des décisions provinciales en matière de dépenses, et ce, dans l’espoir que cela les inciterait davantage à limiter leurs coûts. Ces transferts donnent également aux provinces plus de souplesse dans l’utilisation de ces fonds, qu’elles peuvent dépenser selon leurs besoins les plus pressants, lesquels ne sont évidemment pas les mêmes d’une province à l’autre; il y a aussi des préférences diverses pour le genre de produits et de services que le secteur public doit fournir.

Le sénateur Cohen: Croyez-vous que ce changement a amélioré la prestation des services de santé?

Mme Hoffman: Question difficile. J’ajouterai autre chose à ce qui a déjà été dit, à savoir que la souplesse ne s’applique pas seulement aux décisions provinciales dans l’affectation des montants aux différents secteurs. Cette souplesse s’applique également à la manière dont les provinces dépensent leur argent au sein du système de santé lui-même. Cette souplesse a permis en fait à la plupart des provinces d’élargir, dans certaines conditions, la gamme des services assurés. On peut faire valoir que, étant donné toutes les sommes accordées au cours de ces décennies, les services assurés par les provinces pour les médicaments, les soins à domicile et divers autres services de santé n’auraient pas évolué, si l’on avait conservé la formule 50-50.

However, it is also arguable that perhaps there would have been pressure to apply the 50/50 regime to a wider array of services. It is a little hard to tell. We would all agree that it has been a positive evolution, even with conditions including deductibles, copayments, ineligible populations, and so on. It is good that provinces have chosen to extend the array of chosen services. The difficulty is that they have not done so uniformly, and we have ended up with fragmentation and something of a patchwork across the country.

Senator Cohen: Are you able to tell us something of the strengths and weaknesses of the CHST thus far? Has it been in existence long enough for you to be able to assess that, or is that not a fair question?

Mr. Hoffman: It is not so much that it is a fair or unfair question. It did not add any significantly greater flexibility; therefore the issue really becomes the amount of money available. As money is put back into the CHST, and what we get back in terms of cash, we are already there and beyond if one includes that and tax. However, in terms of the situation of comparable cash to the pre-CHST days, one can say we are back to where we were in pure dollar terms.

Clearly, the issue is not purely money, by any stretch. The question is: What kind of system, structured how, is being financed and supported with the available dollars? I will just stop there.

Senator Keon: I want to compliment you on giving us a very clear, critical path of where we have been since the Second World War. I am now going to try to make you speculate on where we are going.

I want to expand a little, before I go to something else, on your answer to Senator Cohen. I think most health professionals feel that the CHST was a very good thing because it addressed the fundamental question of health, and population health, as it relates to wealth, well-being, social status and so forth. Most knowledgeable people are pressing to have a greater impact in that direction. I think that was a good thing, but what got lost was the accountability. I do not think there is any way of dealing with that problem just now. It was relatively simple when the 50/50 split in dollars existed. This brings me to what I really would like to hear all three of you discuss.

To my way of thinking, we are lacking a structural framework. We have excellent endeavours in population health. We have excellent endeavours in public health. We have some superb health education programs. We have an excellent health care delivery system, despite its problems right now. We are on the verge of having, I think, an absolutely superb research system with the Canadian Institutes of Health Research and a loop that should allow us some early feedback and adjustments and so forth.

On peut, par ailleurs, signaler qu'il y aurait peut-être eu des pressions pour que le régime à frais partagés s'applique à une plus large gamme de services. C'est un peu difficile à dire. Nous sommes tous d'accord pour dire que les choses ont évolué de façon positive, même en tenant compte d'éléments tels que la franchise, la quote-part, les populations inadmissibles, etc. C'est une bonne chose que les provinces aient choisi d'élargir la gamme de services. Le problème c'est qu'elles ne l'ont fait de façon uniforme et que nous nous retrouvons maintenant avec un régime fragmenté, un ensemble de mesures disparates dans tout le pays.

Le sénateur Cohen: Pouvez-vous nous parler des points forts et des points faibles actuels du TCSPS? Ce dernier est-il en place depuis assez longtemps pour vous permettre de l'évaluer? Il n'est peut-être pas juste de vous poser une telle question.

M. Hoffman: Ce n'est pas tant qu'il est juste ou pas de poser la question. Le transfert n'a pas ajouté beaucoup plus de souplesse; par conséquent, ce qui importe en fin compte c'est le montant disponible. À mesure que l'on rétablit le niveau de financement du TCSPS, et avec les montants qui sont réinvestis, nous sommes déjà là et même au-delà, si l'on inclut cela et les impôts. Cependant, si on compare avec la situation qui existait avant le TCSPS, on peut dire que nous sommes revenus à peu près au même niveau sur le plan strictement financier.

De toute évidence, ce n'est pas strictement une question financière, loin de là. La question est la suivante: quel genre de régime, et avec quelle structure, est financé par les fonds disponibles? Je vais tout simplement m'arrêter ici.

Le sénateur Keon: Je tiens à vous féliciter pour cet exposé très clair et très critique de la situation depuis la Seconde Guerre mondiale. Je voudrais maintenant que vous tentiez de nous dire ce que l'avenir nous réserve.

Avant de passer à autre chose, j'aimerais cependant revenir à votre réponse à la question du sénateur Cohen. Je pense que la plupart des professionnels de la santé sont d'avis que le TCSPS est une très bonne chose car il répond aux préoccupations fondamentales en matière de santé, de santé de la population tout en tenant compte de la richesse, du bien-être, du statut social, et cetera. La plupart des gens avertis insistent pour avoir un plus grand impact en ce sens. Je pense que cela a été une bonne chose, mais ce que nous avons perdu, c'est l'obligation de rendre compte. Je ne pense pas qu'il y ait une façon de régler ce problème à l'heure actuelle. C'était relativement simple lorsque nous avions un régime à frais partagés. Cela m'amène à ce dont j'aimerais vraiment que vous nous parliez tous les trois.

À mon avis, ce qui nous manque, c'est un cadre structurel. Nous faisons d'excellents efforts en santé publique. Nous faisons d'excellents efforts en ce qui a trait aux programmes d'éducation. Nous avons un excellent régime de prestation des soins de santé, malgré les problèmes qu'il connaît à l'heure actuelle. Nous sommes à la veille d'avoir je pense un régime de recherche absolument superbe avec les Instituts canadiens de recherche en santé, et nous devrions pouvoir obtenir rapidement des réactions et apporter des modifications au besoin.

Even though you are bureaucrats, you know a lot about this. You have been working in it a long time. Why do you not venture into the political waters where elected politicians would not even dare go, and talk about a structural framework in Canada that could work and could somehow overcome the sensitivities that exist in the provinces and territories?

Ms Hoffman: Are you asking this question because it is past five o'clock?

Mr. Halliwell: I was going to point out that, amongst the three of us, as you well know, Abby can run the fastest.

Ms Hoffman: There is a great deal we could say, but whether it would be appropriate to do so is another matter. Let me address a couple of points, Dr. Keon, on your preliminary comment, and then I will move to your main question.

First, it is true that the cost-sharing regime did allow for a certain degree of accountability because one could simply assess what it was that the provinces submitted, in each case, to receive their 50-cent contribution from the federal level, but as we have all increasingly come to appreciate, all that allowed was a measure of outputs: How many beds there were, how many of certain kinds of services were delivered. The connection between those outputs and health outcomes, and whether the people who needed the services most actually were the ones who got access to them, and whether they were appropriate for optimizing the benefit for the individuals concerned, is a really open question. We would certainly agree that this whole issue of accountability, which depends so much on the adequacy of information, and on which a lot of work is being done now, is really quite critical.

Without sounding like I am dodging your invitation to speculate completely, it really is essential that we have that information in order to think seriously about frameworks for the health system in the future. One of the earlier lines of questioning really got at the nub of any framework, and that is that we need to bring, as I think you have suggested, the preventive side together with the care and treatment side. We need to pay more attention to how we integrate the delivery of services to individuals, that critical interaction with providers, with the provision of services, be it through providers — nurses and physicians — or through public health networks or mass campaigns or whatever. We need to have the individual-based and the population-based approaches to health also integrated. That is at a very highly generalized level, but those seem to me to be among the most critical challenges.

Senator Keon: Do you see an evolution of a structural framework? I am very encouraged by what I see of the interface now between federal-provincial ministers and deputy ministers and bureaucrats at various levels, who are really huddling a lot and exchanging information in a pretty good atmosphere. Do you

Même si vous êtes fonctionnaires, vous savez beaucoup de choses à ce sujet. Vous y travaillez depuis longtemps. Pourquoi ne vous lancez-vous pas dans les eaux politiques ou les politiciens élus n'oseraient même pas s'aventurer, en parlant d'un cadre structurel au Canada qui pourrait fonctionner et sans faire vibrer les sensibiles chez les provinces et les territoires?

Mme Hoffman: Est-ce que vous posez la question parce qu'il est passé 17 heures?

M. Halliwell: J'allais faire remarquer que de nous trois, comme vous le savez, c'est Abby qui peut courir le plus vite.

Mme Hoffman: Nous pourrions dire beaucoup de choses, mais je ne sais pas s'il conviendrait de le faire. Permettez-moi de répondre à quelques points que vous avez soulevés, Dr Keon, lors de vos observations liminaires, avant de répondre à votre principale question.

Tout d'abord, il est vrai que le régime des frais partagés permettait la reddition de comptes dans une certaine mesure car on pouvait tout simplement évaluer ce que les provinces demandaient, dans chaque cas, pour recevoir leur contribution de 50 p. 100 du gouvernement fédéral. Cependant, comme nous avons tous fini par le comprendre, tout ce que cela permettait, c'était d'évaluer les extrants: Combien de lits il y avait, combien de types de services étaient offerts. Il reste vraiment à établir un lien entre ces extrants et les résultats pour la santé et à déterminer si ce sont les gens qui avaient le plus de besoin des services qui y avaient en fait accès et s'il s'agissait vraiment des meilleurs services pour les personnes concernées. Nous sommes certainement d'accord pour dire que toute cette question de la reddition de comptes, qui dépend énormément du caractère adéquat de l'information, et sur laquelle on travaille beaucoup à l'heure actuelle, est une question vraiment importante.

Sans vouloir donner l'impression que j'évite de répondre entièrement à la question que vous m'avez posée, il est vraiment essentiel pour nous d'avoir cette information si nous voulons songer sérieusement à des cadres de travail pour le régime de santé à l'avenir. L'une des questions qui a été posée précédemment allait vraiment au coeur de tout cadre de travail, et comme vous l'avez laissé entendre, je pense, nous devons tenir compte de l'aspect préventif en plus des soins et des traitements. Nous devons accorder davantage d'attention à la façon dont nous intégrons la prestation des services aux particuliers, cette interaction critique avec les fournisseurs de soins, avec la prestation des services, que ce soit par l'intermédiaire de ces derniers — les infirmiers, infirmières et médecins — ou des réseaux de santé publique, de campagnes de masse ou autres. Nous devons par ailleurs intégrer les approches axées sur les particuliers et sur la population. Cela se fait à un niveau très généralisé, mais il me semble que ce sont là les défis les plus importants.

Le sénateur Keon: Voyez-vous une évolution d'un cadre structurel? Je suis encouragé par l'interface que je constate à l'heure actuelle entre les ministres fédéral et provinciaux et les sous-ministres et les fonctionnaires à divers paliers, qui travaillent avec acharnement et échangent de l'information dans un assez

see coming out of that a structural framework that would let us look at the big question of the overall health of our country?

Ms Hoffman: We have certainly seen virtually every minister and every jurisdiction say that a critical and essential route to addressing some of the pressures on the health care system is for us collectively to be doing a much better job on the prevention, promotion and protection sides. There is certainly interest in a more balanced approach in the system overall.

Pursuing that depends, of course, on the degree to which the intense public concerns about what is happening on the care and treatment side can be addressed. It is pretty clear that most citizens, be we bureaucrats, senators, or whoever, knowledgeable about the health system or not, have an instinctive view that prevention and promotion ultimately make sense. However, when people feel that the care and treatment side is vulnerable, they are somewhat resistant, quite understandably, to seeing more energy, and possibly more resources, being devoted to health prevention and promotion, public health, population health, those kinds of activities. We really do need to work on both sides at once, and I think you have commented already that that is the kind of approach that we hear being discussed, and one has reason to be optimistic as a result.

Mr. Halliwell: If you look at the record of this century, the large gains in life expectancy for Canadians have probably been dominated by improvements in prevention of health problems, through obvious means such as general public health measures that were the origin of public health departments, but also other areas such as reduction in accidents, and so on. We may, in some respects, be victims of some of our own successes in this area now, in that the remaining work to be done is perhaps more intractable. What immediately comes to my mind is teenage smoking. Although I am not a parent myself, I understand it is hard to tell teenagers anything. We may be in a world where we have made a lot of progress and we are dealing now with more intractable problems than used to be the case. We should not lose track of that progress we have in fact made in general areas of prevention and in making Canadians more cognizant of the roles their own personal comportment and socio-economic circumstances play in health outcomes.

Senator Robertson: I am interested in three different areas that we have not discussed this afternoon. If you do not have the answers right now, perhaps they could be delivered to me through the clerk.

I should like to know if the levels of staffing and financial support in the approval and inspection services regarding drugs, food protection, and agricultural chemicals — which do not rest with you, although they should — have been increased to more properly handle the approval and inspection process.

bon climat. Croyez-vous que cela permettra d'établir un cadre structurel qui nous permettra d'examiner la grande question de la santé en général au Canada?

Mme Hoffman: Il est certain que tous les ministres et toutes les provinces ont déclaré que si l'on voulait éliminer certaines pressions sur le régime de soins de santé il était essentiel et crucial de faire collectivement un meilleur travail sur le plan de la prévention, de la promotion et de la protection. On cherche certainement à trouver une formule plus équilibrée pour l'ensemble du régime.

Naturellement, cela dépend dans quelle mesure il sera possible il sera possible de répondre aux préoccupations intenses de la population relativement à ce qui se passe sur le plan des soins et des traitements. Il est très clair que la plupart des citoyens, que ce soit nous fonctionnaires, les sénateurs ou d'autres, qu'ils connaissent ou non le régime de soins de santé, sont instinctivement d'avis qu'il est logique en fin de compte de faire de la prévention et de la promotion. Cependant, lorsque les gens ont l'impression que les soins de santé et les traitements sont vulnérables, ils hésitent un peu, avec raison, à ce que l'on consacre davantage d'efforts, peut-être même davantage de ressources, à la prévention et à la promotion de la santé, de la santé publique, de la santé de la population, à ce genre d'activités. Nous devons vraiment travailler sur les deux fronts à la fois, et je pense que vous avez déjà dit que c'était le genre de formule dont on parle à l'heure actuelle, et ce qui laisse croire que nous avons raison d'être optimistes quant aux résultats.

M. Halliwell: Si vous regardez ce qui s'est passé depuis un siècle, les gains importants sur le plan de l'espérance de vie pour les Canadiens sont sans doute attribuables surtout à la prévention des problèmes de santé, grâce à des mesures de santé publique générale évidentes qui ont été à l'origine des ministères de Santé publique, mais aussi dans d'autres domaines, notamment la réduction des accidents, etc. À certains égards, nous sommes peut-être victimes de nos propres succès dans ce domaine à l'heure actuelle, en ce sens que le travail qu'il reste à faire sera peut-être plus difficile. Un problème qui me vient immédiatement à l'esprit est celui du tabagisme chez les adolescents. Bien que je n'ai pas moi-même d'enfants, je comprends qu'il est difficile de dire quoi que ce soit aux adolescents. Nous vivons peut-être dans un monde où nous avons fait beaucoup de progrès et nous devons maintenant nous attaquer à des problèmes beaucoup plus difficiles qu'auparavant. Nous ne devrions pas perdre de vue les progrès que nous avons faits dans le domaine général de la prévention et en rendant les Canadiens plus conscients du rôle qu'ils peuvent jouer pour influencer leur état de santé tant par leur comportement personnel que leurs circonstances socio-économiques.

Le sénateur Robertson: Je m'intéresse à trois différentes questions qui n'ont pas été abordées cet après-midi. Si vous n'avez pas les réponses immédiatement, vous pourriez peut-être me les faire parvenir plus tard par l'intermédiaire de la greffière.

J'aimerais savoir si les niveaux de dotation en personnel et de soutien financier pour les services d'inspection et d'approbation des médicaments, pour la protection des aliments et les produits chimiques agricoles — qui ne relèvent pas de votre responsabilité, même si ce devrait être le cas — ont été

The second question relates to pharmaceutical costs. We hear a lot of complaining about the costs, but we also know that many of the new drugs remove the necessity for patients to stay in expensive hospital beds. Do you have any data that would show the net cost comparison of the effect of six or eight of the new drugs — the wonder drugs — with the cost of treating those patients in the hospital? The information I have been able to gather shows that some of these new drugs result in tremendous savings because they remove the necessity of using a very expensive hospital bed. I would like that comparative data at some time.

The third point is, on page 11-12 of "Health expenditures in Canada" — and I am sure we will have to study these before you come back — if you go down to the transfers to support health, and the graph at the top of that page, you will notice of course that expenditures drop significantly from 1995-1996, but I thought I heard you say we are going to go back up again to that point. I see that graph coming down almost to 50 per cent of 1995-1996 and it makes me a little suspicious. We know that the federal minister has been trying to convince — and he may be right in doing so — the provincial ministers to look at a redesigned health care system that includes many more component parts than now. Is he insisting on that for better health outcomes, or is it because, as I see here for 2004-2005, your financial contribution then drops significantly?

Ms Hoffman: Let me answer the first two questions.

First of all, we will, through the Chair, provide you with information about the budgetary and staffing levels in the Health Protection Branch.

With respect to drug costs, there are two ways of responding to that. One is that we know, at the macro level, that we were all able to cope with reduced expenditures in the hospital sector because the availability of new drugs did eliminate the requirement for hospitalization in certain conditions, or they enhanced the recovery process, et cetera.

There are also a number of smaller-scale, micro studies about particular drugs that would supply you with the kind of insights that you are looking for and that come to the conclusions you drew.

However, it is worth pointing out that there are some other drugs that, while they enhance the quality of life for the individual in question — and I am thinking here now of some of the new drugs we have recently heard about for individuals who have Alzheimer's — will prolong the period over which the more severe form of the disease will affect the individual. The net result

augmentés de façon à améliorer le processus d'approbation et d'inspection.

La deuxième question porte sur le coût des produits pharmaceutiques. On entend beaucoup parler de ces coûts, mais nous savons par ailleurs que beaucoup de nouveaux médicaments permettent aux patients de ne pas occuper de coûteux lits d'hôpitaux. Avez-vous des données qui permettent de faire une comparaison nette des coûts de six ou huit nouveaux médicaments, les remèdes miracle, et du coût du traitement de patients à l'hôpital? D'après l'information que j'ai obtenue, certains de ces nouveaux médicaments entraînent des économies considérables, puisqu'il n'est plus nécessaire d'occuper un très coûteux lit d'hôpital. J'aimerais qu'on me fournisse ces données comparatives.

Troisièmement, à la page 11-12 du document intitulé «Dépenses de santé au Canada» — et je suis convaincue que nous devrons les étudier avant que vous ne reveniez — si vous examinez les transferts à la santé, et le tableau en haut de la page, vous constaterez que les dépenses ont beaucoup baissé depuis 1995-1996. Mais je crois vous avoir entendu dire que nous reviendrions à ce niveau-là, un jour. Dans le tableau, les chiffres baissent de près de 50 p. 100 depuis 1995-1996 et ça sème un doute dans mon esprit. Nous savons que le ministre fédéral a essayé de convaincre — peut-être à juste titre — les ministres provinciaux d'envisager un régime de soins de santé renouvelé qui comporterait de bien plus nombreux éléments que le régime actuel. Insiste-t-il là-dessus dans l'intérêt de la santé des Canadiens ou est-ce parce que, comme je le vois ici pour 2004-2005, votre contribution financière baissera de beaucoup?

Mme Hoffman: Je vais répondre aux deux premières questions.

D'abord, par l'intermédiaire de la présidence, nous vous fournirons de l'information sur les budgets et les niveaux de dotation en personnel à la Direction générale de la protection de la santé.

Au sujet du coût des médicaments, deux réponses sont possibles. Premièrement, nous savons qu'au niveau macro-économique, nous avons tous pu nous débrouiller avec une réduction des dépenses dans le secteur hospitalier grâce à la disponibilité de nouveaux médicaments qui, en effet, éliminaient la nécessité de l'hospitalisation, dans certaines conditions, ou accéléraient la récupération pour les patients, et cetera.

Il y a aussi bon nombre d'études à plus petite échelle, au sujet de médicaments particuliers, et qui vous donneraient les renseignements que vous cherchez pour arriver aux conclusions que vous avez tirées.

Il convient toutefois de signaler que d'autres médicaments, tout en améliorant la qualité de vie du patient — je pense à certains nouveaux médicaments dont on a récemment entendu parler pour les personnes atteintes de la maladie d'Alzheimer — prolongeront la durée de la partie la plus grave de la maladie. Le résultat net, c'est que le patient aura besoin de soins pendant plus longtemps.

of that is that that individual will require care over a longer period of time. Ultimately, the economics are that it is more expensive. The quality of life gain is, of course, tremendous.

In the majority of cases, it cuts the way you suggested, with lesser cost, but there is another side to the coin as well.

Mr. Halliwell: With respect to that chart, it is just a chart of the level of expenditures projected in the fall 1999 fiscal update by the Finance Department. It is the transfers to other levels of government. The top line is total transfers, including equalization, and the second line is the current CHST. In earlier periods, it would have been the Established Programs Financing.

The bottom line is our estimate of the split of the CHST. Clearly, in the current fiscal plan, there are no large increases in the CHST. The position of the Government of Canada is, if agreement is reached on plans to reform the health care system, to obtain a more integrated system in particular, more transfers would be forthcoming. The federal position clearly is that we have to reach agreement on a plan before we reach agreement on a level of funding.

The Chairman: I should like to thank the witnesses most sincerely. It has been a very interesting two hours.

The committee adjourned.

OTTAWA, Thursday, May 4, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 11:04 a.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Before turning to our two witnesses, we have one short item to deal with.

Senator Fairbairn: There is a desire to get the subcommittee on veterans' affairs up and running, and I should like to move that the committee be established under the chairmanship of Senator Meighen.

The Chairman: Do you have a list of members?

Senator Fairbairn: This is a five-member committee. It will include Senator Meighen, Senator Atkins, Senator Kirby, Senator Pénin and myself.

The Chairman: Is there a second for that motion?

Senator Gill: I second the motion.

The Chairman: Any comments? No? I declare the motion passed. We do not need a motion in the Senate. Thank you.

We have a panel of two witnesses this morning. First is Mr. Tom Kent, whom we describe on the material we have circulated to you as a former federal deputy minister. In fact, if we had wanted to do a long history of Mr. Kent's background we

Dans ces cas-là, le coût est plus élevé. Le gain pour la qualité de vie, en revanche, est extraordinaire.

Dans la majorité des cas, comme vous le disiez, les coûts sont plus faibles, mais il faut aussi tenir compte du revers de la médaille.

M. Halliwell: Au sujet de ce tableau, il indique simplement le niveau de dépenses projetées dans la mise à jour relative à la situation financière de 1999, du ministère des Finances. Il s'agit des transferts à d'autres ordres de gouvernement. La première ligne indique le total des transferts, y compris la péréquation, et la deuxième ligne, c'est le TCSPS. Autrefois, on aurait parlé du financement des programmes établis.

À la dernière ligne, vous voyez notre évaluation de la répartition du TCSPS. Il est clair que dans le plan financier actuel, aucune augmentation importante du TCSPS n'est prévue. Le gouvernement du Canada a adopté la position suivante: si un accord est conclu sur des plans de réforme du régime de soins de santé, particulièrement pour un système mieux intégré, davantage de transferts seront consentis. D'après le gouvernement fédéral, il est clair qu'il faut d'abord s'entendre sur un plan, avant de s'entendre sur un niveau de financement.

La présidente: Je tiens à remercier sincèrement les témoins. Ces deux heures ont été très intéressantes.

La séance est levée.

OTTAWA, le jeudi 4 mai 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 11 h 04 pour examiner l'état du système de soins de santé au Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Avant de céder la parole à nos deux témoins, nous devons traiter brièvement d'une motion.

Le sénateur Fairbairn: On souhaite mettre sur pied un sous-comité des affaires des anciens combattants; je propose que ce comité soit créé et que le sénateur Meighen en soit le président.

Le président: Avez-vous la liste des membres?

Le sénateur Fairbairn: Ce comité comptera cinq membres: les sénateurs Meighen, Atkins et Kirby, ainsi que le sénateur Pénin et moi-même.

Le président: Qui veut appuyer la motion?

Le sénateur Gill: J'appuie la motion.

Le président: Y a-t-il des remarques? Non? La motion est adoptée. Il n'est pas nécessaire de faire adopter une motion par le Sénat. Merci.

Nous accueillons ce matin deux témoins. Le premier est M. Tom Kent, dont on dit dans les documents qui vous ont été distribués qu'il a été sous-ministre fédéral. En fait, si on veut la biographie complète de M. Kent, il faut savoir qu'il a été

would have included everything from being the editor of the *Winnipeg Free Press* to having been a senior policy advisor to Mr. Pearson. He was kind enough when I took over the Institute for Research on Public Policy to agree to be the first editor of policy options and, indeed, to have shared an office and a secretary with me at Dalhousie in the late 1970s. Certainly, he is an individual who has been involved in a great many things in Canada that have been truly historical. He is here today because he was the senior policy person at the time that medicare began.

The other person on our panel is Professor Michael Bliss, who is a professor of history at the University of Toronto. Many of us have read many of the things that Mr. Bliss has written and have heard him many times on radio and television. May I say, as a free piece of advertising for him, if you have not seen his lengthy commentary piece on the politics of new Canada and old Canada that was in the paper two days ago, I would urge to you read it. It is a very insightful analysis of the current political scene.

Essentially, senators, we have before us someone who has made history and someone who has written about history. They will each begin with an opening statement and then we will be free to ask them questions on any subject, but particularly with a view to trying to understand the background of what the expectations of government were when they started the national medicare system back in the late 1960s.

Mr. Tom Kent: The subject, as I understood it, was how we came to have public health care insurance, which I shall call medicare for the sake of brevity. Certainly, some early history is now necessary for a complete study, which you are undertaking.

The number of Canadians who knew life before medicare will very soon be, if it is not already, a minority. Of course, how life was before was the essential reason medicare developed. As you all know, before that, treatment could be a financial disaster even for well-to-do people, and many poorer people just did not get care when it was needed. The aim of public policy was quite clearly and simply to change that situation to make sure that people could get care when it was needed without regard to other considerations.

I do not think there is very much for me or Mr. Bliss to say that the committee does not already know. I will therefore try to be brief, which is always difficult. I will also try to relate the history a little bit to the current issues.

I will make a point about perspective, first. There is a lot of discussion about medicare as if it were sort of abnormal, new or strange still. In fact, of course, compulsory health insurance began in Germany 117 years ago, and in a good deal of Europe it was established before the First World War. It entered the Canadian national political picture not all that much later, in 1919, when the national Liberal convention resolved that the federal government should institute, in conjunction with the provinces, an adequate system of insurance against unemployment, sickness, dependence in old age, and other disabilities. Naturally, that was to be done,

rédacteur en chef du *Winnipeg Free Press* et conseiller supérieur en politiques de M. Pearson. Lorsque je suis devenu directeur de l'Institut de recherche en politiques publiques, il a eu la gentillesse d'accepter d'être le rédacteur en chef des options stratégiques et de partager avec moi son bureau et les services de secrétariat lorsque nous nous sommes rencontrés à Dalhousie à la fin des années 70. Il a participé à bien des événements historiques du Canada. Nous l'avons invité parce qu'il était conseiller supérieur en politiques à l'époque où l'assurance-maladie a été instaurée.

Notre deuxième témoin est M. Michael Bliss, professeur d'histoire à l'Université de Toronto. Bon nombre d'entre nous ont lu les textes de M. Bliss et l'avons entendu à maintes reprises à la radio et à la télévision. Je peux même lui faire un peu de publicité gratuite: si vous n'avez pas encore lu son long commentaire sur la politique du nouveau Canada et du vieux Canada paru dans la presse il y a deux jours, je vous encourage à le faire. C'est une analyse pénétrante de la scène politique actuelle.

Essentiellement, chers collègues, nous accueillons un témoin qui a fait l'histoire et un autre qui a écrit sur l'histoire. Ils feront à tour de rôle des remarques liminaires, puis nous pourrons leur poser des questions sur n'importe quel sujet, toujours afin de mieux comprendre ce qu'étaient les attentes du gouvernement lorsqu'il a mis sur pied l'assurance-maladie à la fin des années 60.

M. Tom Kent: Je crois savoir que le thème de notre discussion est ce qui a mené à la création du régime public d'assurance-maladie, que j'appellerai tout simplement l'assurance-maladie. Il est certain que pour mener une étude complète comme celle que vous venez d'entreprendre, il faut remonter dans le temps.

Les Canadiens qui se souviennent de l'époque qui a précédé l'assurance-maladie ne constitueront plus sous peu qu'une minorité, si ce n'est déjà fait. Bien sûr, ce qu'était la vie avant que n'existe l'assurance-maladie constitue la principale raison qui a mené à sa création. Comme vous le savez tous, autrefois, se faire soigner pouvait représenter un désastre financier même pour les biens nantis, et nombreux étaient les pauvres qui ne se faisaient pas soigner lorsqu'ils en avaient besoin. La politique de l'assurance-maladie visait tout simplement à rectifier cette situation et à faire en sorte que les gens puissent obtenir des soins médicaux lorsqu'ils en avaient besoin, sans égard à quelque autre considération que ce soit.

Je ne crois pas que M. Bliss ou moi-même puissions vous apprendre bien des choses. Par conséquent, je tenterai d'être bref, ce qui est toujours difficile. Je tenterai aussi de faire les liens entre l'historique et les enjeux actuels.

Je ferai d'abord une remarque sur le contexte. On a beaucoup discuté de l'assurance-maladie comme si elle était une chose un peu anormale, nouvelle ou même étrange. En fait, l'assurance-maladie obligatoire a pris naissance en Allemagne il y a 117 ans, et elle était établie dans la plupart des pays d'Europe avant la Première Guerre mondiale. Elle a fait son apparition sur la scène politique nationale du Canada peu de temps après, en 1919, lorsque les participants au Congrès libéral national ont adopté une résolution demandant au gouvernement fédéral d'instaurer, en collaboration avec les provinces, un régime

insofar as was practicable, having regard to Canada's financial position.

The period between the world wars was not conducive to social development here or anywhere else. By 1945, as everyone knows, the determination to build reformed societies was strong everywhere. Wartime experience and what government can do had destroyed, for a generation, the essential proposition of laissez-faire that private is good and public is bad. They destroyed it, I say, for a generation. In Canada, that reformist mood was strong at the national political level. I think it is fair to say that if Canada were, by some strange misadventure, a unitary state, we would have had medicare very soon after 1945. As you know, the federal government did, at that time, make extensive proposals, but the provinces — Ontario and Quebec in particular — regarded them as political aggression and would not have anything to do with them.

I would draw a slight parallel to the situation today. If the public will could be directly expressed across Canada, the political pressure to fix the present problems of medicare would be overwhelming. As it is, the federal and provincial levels of government have different agendas. They blame each other and they posture, and as a result we face the frequent Canadian problem of how to achieve collaboration despite the politics of federalism.

After 1945, the federal government went slowly on social reforms but certainly did not give up on them. There were a number of important steps. To understand that, it is perhaps important to remember what only a minority of people do. At that time, Canadian public attitudes were much closer to those in Western Europe than they were perhaps to American or indeed British public attitudes. In fact, I recall a conversation that took place early in the 1950s with the then secretary of state for external affairs, Mr. Pearson. He said to me that in international discussions he usually felt most at home with the Scandinavians. I will not press that point too far as a policy determinant. I do think it is an important strand in understanding the public attitudes of that time.

Partly because of those attitudes, medicare moved on, and of course economic growth greatly increased the confidence of the country to do new things. Saskatchewan bravely led the way. As a result, the views of the provinces shifted and, indeed, some of the provinces helped to pressure the federal cabinet into hospital insurance in 1957. That was a partial measure towards medicare. Some people saw it as a way to head off the pressure for total medicare. Others saw it as a step on the way.

d'assurance contre le chômage, la maladie, la dépendance qu'entraîne la vieillesse et d'autres handicaps. Naturellement, cette résolution ne s'est concrétisée que dans la mesure où c'était faisable en fonction de la situation financière du Canada.

L'entre deux guerres n'a pas été une période propice au développement social, ni ici ni ailleurs. Dès 1945, comme on le sait, on a pu voir partout une forte détermination à réformer la société. L'expérience de la guerre et de ce qu'un gouvernement peut faire avait détruit, pour une génération, le fondement de toute politique de laissez-faire, à savoir que ce qui est privé est bon et ce qui est public est mauvais. Comme je viens de le dire, toute une génération s'est inscrite en faux contre cette affirmation. Au Canada, un fort climat réformiste régnait sur la scène politique nationale. Je crois pouvoir dire que si le Canada avait été, par suite d'une étrange mésaventure, un État unitaire, nous aurions eu l'assurance-maladie peu de temps après 1945. Comme vous le savez, le gouvernement fédéral a alors présenté des propositions exhaustives, mais les provinces — plus particulièrement l'Ontario et le Québec — les ont considérées comme une agression politique et les ont rejetées.

Cela m'amène à faire un parallèle avec la situation actuelle. Si la volonté populaire pouvait s'exprimer directement à l'échelle du pays, les pressions politiques qui s'exerceraient pour que soient réglés les problèmes actuels de l'assurance-maladie seraient considérables. À l'heure actuelle, les paliers fédéral et provincial ont des objectifs différents. Chacun blâme l'autre et se donne des airs, et, en conséquence, nous faisons de nouveau face au problème très fréquent au Canada de savoir comment collaborer en dépit des jeux politiques du fédéralisme.

Après 1945, le gouvernement fédéral a ralenti ses efforts de réforme sociale sans pour autant les abandonner. Des étapes importantes ont été franchies. Pour bien le comprendre, il importe peut-être de se rappeler ce qu'oublie la plupart des gens. À l'époque, les attitudes du public canadien étaient plus près de celles qui prévalaient en Europe de l'Ouest qu'aux États-Unis ou même en Grande-Bretagne. D'ailleurs, je me souviens que, pendant une conversation que j'ai eue au début des années 50 avec le secrétaire d'État aux Affaires étrangères de l'époque, M. Pearson, il m'avait dit que, pendant les discussions internationales, c'est avec les Scandinaves qu'il se sentait le plus à l'aise. Je n'irai pas jusqu'à faire de cette réalité un déterminant politique, mais cela m'apparaît important pour comprendre ce qu'était l'attitude de la population à l'époque.

En partie en raison de ces attitudes, l'idée de l'assurance-maladie a continué de progresser et, bien sûr, la croissance économique a donné au pays la confiance nécessaire pour innover. La Saskatchewan a courageusement ouvert la voie. En conséquence, les provinces ont modifié leurs positions et certaines provinces ont même exercé des pressions sur le Cabinet fédéral pour qu'il adopte l'assurance-hospitalisation en 1957. C'était une mesure qui devait mener à l'assurance maladie pour certains, alors que d'autres estimaient plutôt qu'elle constituait un compromis permettant d'éviter la création d'un régime d'assurance-maladie complet.

I must say that as a step on the way, it proved to have very serious disadvantages that are common in that kind of compromise. The treatment in hospital was free, while seeing the doctor at home, or in an office, was still expensive. Naturally, there was a considerable over-expansion of hospitals. We have been very slow to deal with that situation. Indeed, 40 years later we are still dealing with it, in some cases rather painfully and clumsily. I am afraid that the clear lesson of that experience has not been very well learned.

I groan, frankly, when I hear talk, in federal circles in particular, of separate financial support for home care or pharmacare or whatever is the hot button. That would make a political splash, but that sort of division of the total health care service would be disastrous. Health care of high quality can be efficiently delivered according to need, but only if there is coordinated management in the community of the comprehensive services — the components of the whole health care system. Separate bags of money are certainly not the way to reform health care.

It has been said that in 1957 I suggested an alternative to hospital insurance as the way to medicare. I think it would have been a better compromise, but it was not taken seriously. I will not waste your time with it now.

It is important that the Liberal Party, having moved very shortly after 1957 into opposition, promptly did treat hospital insurance as a step to full medicare. That was expressed somewhat vaguely as things tended to be in the resolutions of the 1958 Liberal Party conference. However, the seed germinated and in the January 1961 national policy rally of the Liberal Party, comprehensive, universal health care was given pride of place in the policy resolutions. I would say that that was the decisive point when the die was cast for nation-wide medicare. The rally, I remind you, preceded the Saskatchewan Medical Care Insurance Act that was greeted by a doctor's strike in July 1962. I think it was also the resolution of the Liberal Party that stimulated the appointment by the then government, in the summer of 1961, after the rally, of the Hall commission, the Royal Commission on Health Services, which eventually reported three years later.

I have made a set of convention resolutions that were decisive; of course, we all know that often convention resolutions are not by any means binding on political leaders. However, in this case, the commitment to health care was made central to the formal policy statements of the signature of Mr. Pearson, which were the Liberal Party's platform for 1962 and 1963. That still left a lot to be done, of course. Mr. MacEachen struggled with a lot of opposition in order to get the Medical Care Act passed in 1966 and even more opposition within his own ranks to get it implemented in 1968. Still, I would say that from 1961 onwards, it was reasonable to be confident that medicare would come; the questions were when and in what form.

Cette mesure comportait tous les inconvénients communs à ce genre de compromis. Le traitement à l'hôpital était gratuit, alors que les consultations du médecin à la maison ou au bureau étaient encore coûteuses. De plus, les hôpitaux se sont agrandis et sont vite devenus trop grands. Il nous a fallu beaucoup de temps pour réagir à la situation. D'ailleurs, 40 ans plus tard, elle n'a toujours pas été corrigée et nos efforts, dans certains cas, sont maladroits et douloureux. Nous n'avons pas su tirer des leçons de cette expérience.

Honnêtement, cela me fait grogner que d'entendre, surtout dans les cercles fédéraux, parler de soutien financier distinct pour les soins à domicile, l'assurance-médicaments ou tout autre sujet qui est le sujet de l'heure. Cela ferait du bruit politiquement, mais cette compartimentalisation des services de soins de santé serait désastreuse. On peut dispenser efficacement des soins de santé de grande qualité en fonction des besoins, mais seulement si, au sein de la collectivité, on sait gérer de façon coordonnée tous les éléments du système de soins de santé. Ce n'est pas en prévoyant des budgets distincts pour chacun de ces éléments qu'on réformera les soins de santé.

On a dit que, en 1957, j'avais suggéré une mesure de remplacement de l'assurance-hospitalisation qui aurait pu mener à l'assurance-maladie. Cela aurait été un meilleur compromis, à mon avis, mais ma proposition n'a pas été prise au sérieux. Je ne vous ferez donc pas perdre votre temps avec cela aujourd'hui.

Peu de temps après 1957, le Parti libéral s'est retrouvé dans l'opposition et s'est mis à considérer l'assurance-hospitalisation comme une mesure qui mènerait à l'assurance-maladie complète. Cela s'est traduit de façon plutôt vague, comme l'époque le voulait, dans les résolutions adoptées au congrès du Parti libéral en 1958. Dans les années qui ont suivi, l'idée a fait du chemin et, aux assises de politique nationale du Parti libéral de janvier 1961, l'idée d'un régime exhaustif et universel de soins de santé s'est vu accorder une place de choix dans les résolutions. Je dirais que c'est à ce moment que la partie s'est jouée pour l'assurance-maladie nationale. Je vous rappelle que ces assises ont précédé l'adoption de la Saskatchewan Medical Care Insurance Act à laquelle les médecins ont répondu en déclenchant une grève, en juillet 1962. À mon avis, c'est la résolution du Parti libéral qui a mené à la création, par le gouvernement de l'époque, à l'été de 1961, de la Commission Hall, la Commission royale d'enquête sur les services de santé qui a fait rapport trois ans plus tard.

J'ai présenté des résolutions, à des congrès, qui ont été décisives; bien sûr, nous savons tous que les résolutions adoptées en congrès ne lient en rien les dirigeants politiques. Toutefois, en l'occurrence, l'engagement à instaurer l'assurance-maladie était au cœur des énoncés de politique de M. Pearson qui ont constitué le programme du Parti libéral en 1962 et 1963. Il y avait encore beaucoup à faire, bien sûr. M. MacEachen a dû surmonter une opposition féroce pour faire adopter, en 1966, la Loi sur les soins médicaux, opposition qui s'est faite encore plus féroce dans les rangs de son parti quand est venu le moment de mettre en œuvre la loi, en 1968. Néanmoins, je dirais qu'à partir de 1961, il était raisonnable de croire que l'assurance-maladie deviendrait réalité; il ne restait plus qu'à déterminer quand et sous quelle forme.

Of course, the answers turn essentially on the federal-provincial relationship. Provincial programs, as health programs must be, can add to national medicare, or whatever, only if they are the same in some of their main features, and that will not happen without a federal contribution. In the case of the Medicare Act, the amount was effectively fixed already by hospital insurance. Essentially, 50 per cent of the costs were covered by the federal government. There was no possibility of introducing the doctors' part of medicare on any lesser formula.

However, how were 50 per cent of the costs reckoned? Hospital insurance had been based on provinces signing agreements that required them to give quite detailed undertakings and be involve in a good deal of federal vetting of what they did. There were objections of principle to that as an intrusion of jurisdiction and a distortion of provincial priorities. Certainly, also very important to both provincial and federal governments, it was very tiresome to administer. Resentment was raised to a fevered pitch, not by the hospital insurance program but by another piece of legislation, the technical and vocational training programs, which were a horror of detailed federal regulations as a condition of extensive cost sharing.

The effect of that was that the whole report was not as helpful as we had hoped it would be. As you know, it made the case for complete medicare with enormous force and conviction, but it assumed that it could be done by repetition of the same kind of cost sharing as had been used for hospital insurance. That, of course, was impossible. In the federal proposal of 1965 to the provinces there had to be found a different way of securing federal participation in a scheme that, though it comprised ten provincial medicare programs, would be consistent on a nationwide basis. That formula, as you all know, was that the federal government would contribute 50 per cent to the cost of medicare programs that conformed to certain basic principles — comprehensive, universal, portable, and publicly administered. The provinces did not have to sign agreements or submit to federal supervision. The provinces were never entirely happy with the details of that scheme, in part for very good reasons, in my view, but so far they have all gone along with what has been, up to now, fairly consistent nationwide medicare.

However, the 1966 act proved to have flaws. It did not clearly rule out charges and extra billing. That was corrected, of course, in the health act of 1984, which consolidated the hospital and medical provisions, defined the four principles more clearly, and added a fifth, accessibility — that is to say, access not to be impeded by any charges.

I must comment on the issue of two-tier health care, which is now so frequently raised and which of course the issue of extra billing involved. This issue is sometimes a straw man. People often talk as if medicare meant that people are prevented from

Bien sûr, les réponses à ces questions sont liées aux relations fédérales-provinciales. Les programmes provinciaux que sont les programmes de santé peuvent s'ajouter à l'assurance-maladie nationale seulement si certains des principaux éléments lui sont identiques, ce qui ne saurait être sans une contribution fédérale. Dans le cas de l'assurance-maladie, le montant était déjà fixé par l'assurance-hospitalisation. Essentiellement, 50 p. 100 des coûts étaient assumés par le gouvernement fédéral. Il n'était pas possible de prévoir la rémunération des médecins selon une autre formule.

Toutefois, comment ces 50 p. 100 des coûts étaient-ils calculés? Pour l'assurance-hospitalisation, les provinces avaient signé des accords qui exigeaient d'elles qu'elles fournissent des rapports détaillés et consentent à ce que le fédéral avalise une bonne part de leurs décisions. On s'est opposé, en principe, à cela sous prétexte qu'il s'agissait d'une ingérence dans une compétence provinciale et d'une distorsion des priorités provinciales. De plus, et c'était important autant pour les gouvernements provinciaux que pour le gouvernement fédéral, le système était lourd à administrer. Ce n'est pas le programme d'assurance-hospitalisation, mais une autre mesure législative qui a porté le ressentiment à son comble: les programmes de formation technique et professionnel dont les coûts étaient partagés aux termes d'une réglementation fédérale si détaillée qu'elle en était cauchemardesque.

Résultat: le rapport dans son ensemble ne nous a pas été aussi utile que nous l'avions espéré. Vous savez qu'il plaidait la cause, avec force et conviction, de l'assurance-maladie complète, mais il tenait pour acquis que cela pourrait se faire dans le cadre d'accords de partage des coûts, à l'instar de l'assurance-hospitalisation, ce qui était bien sûr impossible. Dans la proposition fédérale aux provinces de 1965, il fallait trouver une autre façon de garantir la participation fédérale à un régime qui, bien que comprenant dix programmes provinciaux d'assurance-maladie, serait uniforme à l'échelle du pays. On a décidé que le gouvernement fédéral contribuerait à hauteur de 50 p. 100 aux coûts des soins médicaux qui respecteraient certains principes de base: l'intégralité, l'universalité, la transférabilité et l'administration publique. Les provinces n'étaient pas tenues de signer des accords ou de se soumettre à la surveillance du fédéral. Les provinces n'ont jamais été entièrement satisfaites des détails de ce régime, et je dirais qu'elles avaient un peu raison —, mais jusqu'à présent, elles s'y sont conformées et nous avons pu jouir de soins de santé assez uniformes d'un bout à l'autre du pays.

Toutefois, la loi de 1966 comportait des défauts. Elle n'interdisait pas clairement les frais et la surfacturation. On a corrigé cela dans la Loi canadienne sur la santé de 1984 où l'on a rassemblé les dispositions concernant les soins hospitaliers et les soins médicaux, défini plus précisément les quatre principes et ajouté un cinquième, celui de l'accessibilité — c'est-à-dire que les frais de doivent pas faire obstacle à l'accès aux soins de santé.

Je me dois de faire quelques remarques sur la question du système de soins de santé à deux niveaux qu'on soulève souvent ces jours-ci et qui implique bien sûr la surfacturation. Cette question sert souvent d'homme de paille. On entend souvent dire

buying their own health care. Of course that is nonsense. People with money can and always will be able to buy what they want. That is "separate" medicine; it is not two-tier medicine. Two-tier would be quite different. It means that some facilities and personnel can provide two levels of care: one without charge to the patient, and the other, though also tax-financed probably in large part, with supplements and priorities that are privately financed.

It is that second tier that would destroy the democratic principle in health care. It would draw resources from tax-provided care, diminish its range and quality and remove the basic objective that care be provided, as far as possible, according to need and not for other considerations.

As yet, the main attack on medicare has not come from "two-tierdom," from Mr. Klein or from anyone else. It has come over a good many years from federal governments. Medicare was not built on principles for the provinces alone. It was also built on federal principles, and the crucial federal principle was its commitment to share in the costs of the provinces. That commitment has been increasingly dishonoured ever since 1977, and in 1995 it was completely tossed aside. In 1997, as you know, the form of financing was switched in part to a transfer of taxes instead of a cash transfer. That had its merits, but at the same time the opportunity was taken to decouple the total from provincial health costs and relate it instead to the GNP. Subsequently, by unilateral federal decisions, that relation was increasingly diminished, and finally, with the CHST, the Canada Health and Social Transfer, all vestige of a formula was removed. The transfer became an arbitrary sum determined entirely according to federal financial and political convention.

Political pressure has since led to some restoration of the original cuts, but there has been no restoration of the principle of federal commitment. It is said that more money will be available if and when the provinces agree to improvements in medicare and so on. That is the technique of going nowhere by insisting on putting the cart before the horse.

For better or worse, delivering health care is provincial business. There will be collaboration and there can be national consistency if there is federal financial help. However, what is significant is not so much the amount of that help but that, if there is to be the planning of efficient, comprehensive health care, it must be based on an assurance of financing. Part of that financing must be federal if we are to have consistent national programs, and it is important that that federal share be committed in relation to provincial costs.

que l'assurance-maladie empêche les gens d'acheter leurs propres soins de santé, ce qui est faux, bien sûr. Ceux qui ont de l'argent peuvent et pourront toujours acheter ce qu'ils veulent. Ce sont là des soins de santé «distincts», et non pas un système de soins de santé à deux niveaux, qui serait bien différent. Ce serait un système où le personnel et les installations permettraient la prestation de deux niveaux de soins: l'un gratuit pour le patient, l'autre, aussi financé à même les recettes fiscales en grande partie, comportant des suppléments et des priorités financés par le secteur privé.

C'est ce deuxième niveau qui détruirait le principe démocratique de l'assurance-maladie. Il tirerait des ressources des soins publics, diminuerait la qualité et le choix des services et ferait fi de l'objectif fondamental selon lequel les soins doivent être dispensés, dans la mesure du possible, selon les besoins et pour aucune autre considération.

Pourtant, jusqu'à présent, la principale attaque qu'a dû essuyer l'assurance-maladie n'est pas le risque que soit créé un système de soins de santé à deux niveaux, ni M. Klein ni qui que ce soit d'autre. Ce sont les gouvernements fédéraux des dernières années. L'assurance-maladie ne se fonde pas que sur des principes visant uniquement les provinces. Elle se fonde sur des principes qui visent aussi le gouvernement fédéral, dont le plus crucial et celui qui veut que le gouvernement fédéral s'engage à partager les coûts des provinces. Depuis 1977, on respecte de moins en moins cet engagement et, en 1995, on en a complètement fait fi. En 1997, comme vous le savez, on a modifié la forme de financement qui se fait par le biais d'un transfert fiscal plutôt que par un transfert pécuniaire. Cette formule a ses mérites, mais on a aussi saisi l'occasion pour se fonder non plus sur le coût total des soins de santé de la province, mais plutôt sur le produit intérieur brut. Par la suite, le gouvernement fédéral a décidé unilatéralement d'en tenir de moins en moins compte et, avec le TCSPS, le Transfert canadien en matière de santé et de programmes sociaux, les derniers vestiges de cette formule ont disparu. Le transfert est devenu une somme arbitraire déterminée uniquement en fonction des positions politiques et financières du gouvernement fédéral.

La pression politique qui s'est exercée depuis a permis le rétablissement d'une part des sommes qui avait été supprimées, mais le principe de l'engagement du fédéral à partager les coûts n'a pas été rétabli, lui. On dit que des sommes seront mises à la disposition des provinces lorsqu'elles accepteront d'améliorer leurs soins de santé, et ainsi de suite. Ainsi, on ne va nulle part puisqu'on insiste pour mettre la charrue devant les boeufs.

Pour le meilleur et pour le pire, la prestation des soins de santé relève des provinces. Il y aura collaboration et il pourrait y avoir uniformité à l'échelle du pays avec l'aide du palier fédéral. Toutefois, ce qui importe, ce n'est pas tant par quelle somme d'argent cette aide se traduira, mais plutôt, si on veut planifier la prestation de soins de santé complets et efficaces, la garantie qu'ils seront financés. Le gouvernement doit assurer sa part du financement s'il tient à ce qu'il y ait des programmes nationaux uniformes, et il importe que la part du fédéral soit calculée en fonction des coûts qu'assument les provinces.

I emphasize that it is not the exact amount of that transfer that is important but rather that the amount be based on provincial costs, not on federal whims or federal convenience. That basic decision to return to some firmly assured type of federal contribution is absolutely essential to maintaining and improving health care across this country. I would say that it is even more important, if that is possible, for another reason: it is essential to restore federal integrity to the intergovernmental collaboration that is crucial to the working of our federalism. If that is done, if there is a clear recommitment of firmly assured federal share of costs, then, in my view, although the medicare problems will remain tough, they will be in no way overwhelming.

The Chairman: Thank you, Mr. Kent.

Please proceed, Professor Bliss.

Professor Michael Bliss, University of Toronto: Thank you very much for inviting me to appear before your committee. I commend the committee for holding these hearings. If this is not the top item on our national agenda it is very close and it will not go away. However we differ, holding a serious discussion in which there are no sacred cows about health care and its future is exactly what we hope our legislators will do.

I was asked to appear on fairly short notice but I was able to prepare a brief that is a revision of an historical presentation I made last year to an OMA conference. You have copies of that. It covers some of the same ground that Mr. Kent did. I must say that to talk about the history of health care in the presence of Tom Kent is like speaking learnedly about floods while sitting next to Noah.

I want to comment on only four aspects of my brief. The first and possibly most important thing I have to say is about the context of our intense concern for health and health insurance. Historically, over 100 years we have invested so many resources in health care and we have won so many battles against disease. The history of modern medicine is a history of great triumphs. We have utterly destroyed some of the greatest and most devastating plagues known to humankind. Smallpox, for example, does not exist. With the antibiotic revolution of the 1940s, we were able to defeat TB and many other terrible diseases. Medical science takes us from one victory to another. We are, by all accounts, the healthiest peoples in history. Every generation is becoming healthier, and that is wonderful progress.

The trouble is that, with all our progress, health care costs do not go down. We find ourselves in the strange paradox that the healthier we become, the more we spend on health. That is unusual when you make comparisons with other perils that we manage to conquer over time. A hundred years ago I suppose the ordinary family was terrified of two things: ill health and fire — being burned out. In the last hundred years, for the most part the

J'insiste sur le fait que ce n'est pas le montant du transfert qui compte, mais plutôt que le montant soit établi en fonction des coûts assumés par les provinces, et non en fonction des caprices du fédéral ou de ce qui lui convient. Il est essentiel qu'on rétablisse une contribution garantie du fédéral pour maintenir et améliorer les soins de santé à l'échelle du pays. C'est d'autant plus important puisque c'est aussi essentiel pour redonner à la collaboration intergouvernementale l'intégrité fédérale si cruciale pour notre fédéralisme. S'il prend cette décision, si le gouvernement fédéral garantit qu'il assumera une part donnée des coûts, à mon sens, bien que les problèmes des soins de santé ne seront pas tous réglés, ils ne seront plus insurmontables.

Le président: Merci, monsieur Kent.

Professeur Bliss, la parole est à vous.

M. Michael Bliss, professeur, Université de Toronto: Je vous remercie de m'avoir invité à témoigner devant votre comité que je félicite d'ailleurs de tenir ces audiences. Même si ce n'est pas la question qui est au sommet de l'agenda de la nation, elle y occupe néanmoins une place prépondérante et elle ne s'évanouira pas du jour au lendemain. Quelles que soient nos divergences, le fait de tenir une discussion sérieuse sur le régime de santé et son avenir, sans exclure quoi que ce soit, c'est exactement ce que nous espérons de nos législateurs.

On m'a demandé de témoigner à bref préavis, mais j'ai néanmoins pu composer un mémoire qui reprend essentiellement l'historique que j'avais présenté l'an dernier à l'occasion d'une conférence de l'OMA et dont vous avez copie. Ce texte parle à peu près des mêmes choses que M. Kent et je dois avouer que pour moi, parler de l'historique du régime de santé en présence de Tom Kent revient un peu à prétendre parler avec assurance d'une inondation en présence de Noé.

Je voudrais simplement commenter quatre volets de mon mémoire. La première chose que je voudrais vous dire, qui est peut-être la plus importante aussi, concerne la profonde inquiétude que nous nourrissons à propos de la santé publique et de l'assurance-santé. Rétrospectivement parlant, nous avons énormément investi dans la santé et nous avons remporté énormément de batailles contre les maladies depuis un siècle. L'histoire de la médecine moderne est une succession de victoires éclatantes. Nous avons totalement éradiqué certains des fléaux les plus graves et les plus dangereux pour le genre humain. Ainsi, la variole a entièrement disparu. Avec l'avènement des antibiotiques dans les années 40, nous avons pu vaincre la tuberculose et bien d'autres maladies redoutables. La médecine nous a conduits de victoire en victoire. À tous égards, nous sommes parmi tous les peuples de l'histoire celui dont la santé est la meilleure. Chaque génération est en meilleure santé que la précédente, et cela est un progrès merveilleux.

Le problème est que tous ces progrès n'ont pas fait baisser le coût des services de santé. Nous nous trouvons face à un bien étrange paradoxe, en ce sens que plus la santé publique s'améliore, plus la santé nous coûte de l'argent. Voilà qui est inhabituel si l'on songe aux autres dangers que nous finissons, au fil du temps, par éloigner. J'imagine qu'il y a 100 ans, une famille ordinaire craignait avant tout deux choses: la maladie et

fear of fire has diminished in our society as we have developed fireproofing techniques, and the cost of fire insurance has shrunk to a very minor part of most of our budgets. The cost of health care, however, does not shrink. It just keeps growing. This realization is absolutely essential as we look to the future.

There are no savings, long-term, in health care. You cannot do it. The reason is the problem of human mortality. All your victories against ill health are simply temporary victories or postponements, because we have not changed human mortality by one iota. It is 100 per cent, give or take a little bit depending on what you think of Elvis. It will not change. In effect, our problems are increasing because of our success. I refer to the problem of health care as almost perfectly analogous to the problem of keeping a snowman from melting. You get the easy victories in January and February, but then you push the problem into March and April. The cost becomes higher and higher. The more success you have, the more problems you have. In the 21st century, we are facing the problem of an aging population that is aging because we have been so successful. However, it is building up more and more health care costs. That is a trap in which we find ourselves and there is absolutely no way out of it.

Some of the ethicists on the frontiers talk about euthanasia, but I find that profoundly dissatisfying. That is the context within which all of our talk about health insurance and its future must be seen. In the past, it was not seen terribly clearly. In Mr. Kent's days, when they did the projections about health care costs, they did not see, 30 years on, that we would have a \$180-billion-a-year industry. Only nowadays are we doing the projections on into 2020. The people particularly in the provincial ministries are saying that in another 20 years, with the projected increases in health care costs, our provincial governments will become gigantic HMOs that will happen to have a few other departments that go along with them. This is an enormous problem.

Let me turn now to the history here. Mr. Kent has given you the background, the deep interest in health insurance, which goes back to the 19th century. In Canada, there was certainly a long run up to medicare. I point out in my brief that concern for health insurance existed before there was a CCF or NDP. It was the Liberal Party that first committed to national health insurance in 1919. We have a very odd and checkered background. The first doctors' strike in Canada was in Winnipeg, in 1933, as doctors went on strike to try to force the state to pay them for looking after the indigent because they were doing so much health care for free. In the early days, there was a deep physician interest in

l'incendie. Depuis 100 ans, le risque d'incendie a pour l'essentiel beaucoup diminué dans notre société étant donné que nous avons découvert des méthodes pour nous prémunir de l'incendie, de sorte que le coût de l'assurance-incendie est devenu une fraction minime du budget ménager. En revanche, le coût de la santé publique n'a pas diminué, bien au contraire. Lorsque nous pensons l'avenir, c'est là un élément qu'il est essentiel de garder présent à l'esprit.

En matière de santé publique, il n'y a pas d'économies à long terme. C'est impossible. La raison en est le problème de la mortalité du genre humain. Toutes nos victoires contre la maladie sont simplement des victoires temporaires, des remises à plus tard, étant donné que nous n'avons pas fait bouger d'un iota la mortalité du genre humain. Elle demeure à 100 p. 100, plus ou moins selon ce qu'on pense au sujet d'Elvis Presley. Mais cela ne changera pas. Au contraire, nos problèmes augmentent en raison même de notre réussite. Pour moi, le problème des soins de santé est en analogie pratiquement parfaite avec celui du bonhomme de neige qu'on essaierait d'empêcher de fondre. En janvier et en février, la victoire est facile, mais cette victoire ne fait que repousser le problème à mars et à avril. Le coût augmente de plus en plus. Plus on réussit, plus on crée de problèmes. Au XXI^e siècle, nous sommes confrontés au problème d'une population vieillissante, une population qui vieillit en raison même de nos succès. Mais ce succès alourdit d'autant la facture des soins de santé. C'est un piège dans lequel nous nous trouvons et dont il nous est impossible de sortir.

Certains éthiciens marginaux parlent bien d'euthanasie, mais je trouve cette attitude profondément insatisfaisante. Voilà donc le contexte dans lequel il faut placer tout ce que nous disons à propos de l'assurance-santé et de son évolution future. Jusqu'à présent, on ne voyait pas trop clairement ce genre de choses. À l'époque de M. Kent, lorsqu'on faisait des projections au sujet du coût des services de santé, il était impensable d'envisager que, 30 ans plus tard, ce domaine représenterait une industrie de 180 milliards de dollars par an. Ce n'est que très récemment que nous faisons des projections jusqu'à l'an 2020. On dit maintenant, surtout dans les ministères provinciaux, que dans 20 ans, étant donné l'augmentation des frais de santé qu'on peut envisager, nos gouvernements provinciaux vont devenir de gigantesques organisations de soins de santé intégrés auxquelles se grefferont, incidemment, un tout petit nombre d'autres ministères. Voilà un problème considérable.

Permettez-moi maintenant de passer à l'historique. M. Kent vous a donné le contexte, vous a expliqué pourquoi on s'intéressait tellement à l'assurance-santé, et ce depuis le XIX^e siècle. Au Canada, le régime d'assurance-maladie était certainement très attendu. Je signale dans mon mémoire que c'était un fait avant que n'existe même le CCF ou le NPD. C'est le Parti libéral qui s'est le premier engagé à un régime national d'assurance-maladie en 1919. Nous avons une histoire très variée. La première grève des médecins au Canada a eu lieu à Winnipeg en 1933 et la grève a consisté à essayer de forcer l'État à payer les médecins qui s'occupaient d'indigents parce qu'ils travaillaient

health insurance, because for many of them it would mean that they would be paid.

I endorse Mr. Kent's view that, in the years after World War II, Canadians thought that the public policy issue of health insurance probably could be dealt with effectively only by the state. There was not a golden age of private health insurance in Canada. The issue is partly analogous to the pension issue, when it was seen that there was a serious problem with low-income people saving for their retirement and only the state had the resources to provide pension entitlements to the aged. Similarly, although private health insurance developed rapidly in the 1950s and 1960s, the private industry began running into all the problems that still plague private health insurance in the United States. There is a bias for private insurers to pick healthy people. There is a problem of whether you will have first dollar coverage or comprehensive coverage, and so on.

While some politicians in the 1960s — for example, John Robarts in Ontario — did think that it was possible to work out a private/public mix in health insurance, a large number of people bought into the view that probably the whole problem had to be handled by turning it over to the state where the state becomes the insurer of everyone. I defer to Mr. Kent's account of how they produced medicare in 1968.

In my brief, I quote from the Hall commission, which said, in 1964, that it was time that Canada moved to a situation in which the fruits of health science are available to Canadians without hindrance. I think that is a nice concept.

In the 1960s, removing the hindrance meant removing the financial barriers. That was a great breakthrough in social policy. Many of us remember the kind of golden age of Canadian health care that existed from about 1968 to the early 1970s, when it was seen to be a free good to all of us. We suddenly went into our doctors' offices and there were no more bills. Patients were wonderfully happy and physicians were wonderfully happy because they were being paid 100 cents on the dollar. It looked as though all the health care you wanted was available without any cost.

The most important part of the story is the 1970s, when, very quickly, the public insurers realized they had a huge problem because they had given blank cheques to Canadians and their health care providers. In the 1970s, the problem of paying for health insurance quickly became the most serious thing that ministries of health, both provincial and federal, had to face. Immediately, the question of how to contain health care costs came to the fore, and a whole cadre of experts and health care economists grew up to try to give advice to state insurers on how you could stop the escalation of costs. We remember the 1970s of stagflation, in which the overall costs of Canadian social programs began to be a terrible burden on governments. The Trudeau government felt the full force of it. It responded in many ways and provincial governments responded in many ways, but they began to try to squeeze the providers of health care, the hospital system and the physicians in order to try to hold down costs.

énormément à titre gracieux. Au début, les médecins s'intéressaient beaucoup à l'assurance-santé parce que, pour beaucoup d'entre eux, cela leur permettrait d'être payés.

Je suis d'accord avec M. Kent lorsqu'il dit qu'après la Seconde Guerre mondiale, les Canadiens pensaient que la question d'un régime public d'assurance-santé ne pourrait probablement être réglé que par l'État. Il n'y a jamais eu au Canada d'âge d'or de l'assurance-santé privée. C'est un peu comme la question des pensions, quand on a constaté que c'était un gros problème pour les faibles revenus qui ne pouvaient économiser pour leur retraite et qu'ainsi, seul l'État avait les ressources pour verser une pension de retraite aux personnes âgées. De la même manière, bien que les régimes d'assurance-santé privés se soient développés rapidement dans les années 50 et 60, le secteur privé a commencé à rencontrer des problèmes qui n'ont toujours pas disparu aux États-Unis. Les assureurs privés ont tendance à servir de préférence les personnes en bonne santé. Il y a la question de la couverture au premier dollar ou de la couverture complète, et cetera.

Lorsque certains politiques dans les années 60 — comme John Robarts en Ontario — étaient convaincus qu'il était possible de parvenir à un régime d'assurance-santé mixte privé/public, beaucoup de monde ont pensé que tout le problème devait probablement être mis entre les mains de l'État qui deviendrait l'assureur de tous. M. Kent vous a raconté comment est née l'assurance-maladie en 1968.

Dans mon mémoire, je cite la commission Hall, qui déclarait, en 1964, qu'il était temps que le Canada en arrive à une situation dans laquelle les fruits des sciences médicales seraient mis à la disposition de tous les Canadiens sans restriction. Je trouve que c'est un joli concept.

Dans les années 60, éliminer des restrictions signifiait éliminer des obstacles financiers. Ce fut une grande avancée en politique sociale. Nombre d'entre nous se souviendront de ce genre d'âge d'or du régime de santé publique canadien que nous avons connu entre 1968 et le début des années 70, lorsque l'on a considéré qu'il s'agissait d'une denrée gratuite pour tous. Tout d'un coup, nous allions chez le médecin et ne payions pas de note en sortant. Les patients étaient ravis et les médecins aussi parce qu'ils étaient payés 100 c. par dollar. On a eu l'impression que l'on pouvait bénéficier de tous les soins de santé sans que cela ne coûte rien.

L'élément le plus important de cette histoire remonte aux années 70 quand, très rapidement, les assureurs publics se sont aperçus qu'ils faisaient face à un problème énorme parce qu'ils avaient donné des chèques en blanc aux Canadiens et à leurs fournisseurs de services de santé. Le problème du paiement de cette assurance-santé est rapidement devenu le plus grave problème que rencontraient les ministères de la Santé, au niveau provincial et au niveau fédéral. On s'est tout de suite demandé comment contenir ces frais et tout un éventail d'experts et d'économistes en matière de santé ont tout d'un coup essayé de conseiller les assureurs publics quant à la façon de mettre fin à cette escalade des coûts. Nous nous souvenons de l'époque de stagflation des années 70 lorsque les coûts globaux des programmes sociaux canadiens ont commencé à représenter un fardeau terrible pour les gouvernements. Le gouvernement Trudeau l'a ressenti pleinement. Il a réagi à bien des égards, tout

The providers responded the way anyone else does when they are squeezed: They began to look for alternatives. The medicare system of 1968 was a pluralist system that allowed for the freedom of providers to practise outside the system. You could opt out; you could extra bill. It was not surprising, then, in the 1970s, that, as the provincial governments began to squeeze the medicare fee schedule, more and more practitioners opted out. By the end of the 1970s and early 1980s, a kind of re-privatization occurred in health care. Many people saw the public system as a penny-pinching system and they wanted to work in the private sector where there was more freedom, more protection of incomes, and more possibilities for innovation.

By the early 1980s, we were seeing across the country serious problems in our medicare system. So many specialists had opted out that, in large parts of the country, it was impossible to have access to certain specialists under medicare. That was particularly true in obstetrics and gynaecology. The issue of accessibility became very important. The Trudeau government finally decided that the only way to protect the public health care system was to close off the private alternative.

That was the essential decision that led to the Canada Health Act. There are various ways of phrasing this. The exact language used is fraught with connotations. The state set out to protect the accessibility of the system by, in effect, outlawing private health care in essential medical and hospital services. To put it another way, the Canada Health Act was a legislative wall that created a state monopoly in medicare. The crumbling of the medicare system appeared to be inevitable without that kind of legislative bulwark.

We have had 16 years of experience since then. What has happened? The inexorable mounting of health care costs simply continues. The pressure on the state system has continued. The protection provided by the Canada Health Act allowed cost controls to be brought into the state system without the kind of fear seen in the 1970s because the providers could not go anywhere else.

We have had more experiments with cost control, the most significant of which has been the belief by some health care economists that you could reduce demand for health care by limiting the supply of physicians and nurses and other health care providers. You will undoubtedly hear the view that health care is a strange industry in which suppliers create demand. If the system graduates a new doctor, he or she will generate patients. That led to the decision in the early 1990s to limit the supply of physicians. That decision, among others, will lead to huge problems in the future.

comme les gouvernements provinciaux, mais ils ont commencé à limiter les ressources des fournisseurs de soins, des hôpitaux et des médecins afin d'essayer de juguler cette escalade des coûts.

Les fournisseurs ont réagi comme on peut s'y attendre dans ces circonstances: ils ont commencé à rechercher des solutions de rechange. Le régime d'assurance-santé de 1968 était un régime pluraliste qui leur donnait la possibilité d'exercer en dehors du système. Ils pouvaient choisir de ne pas y participer; et ils pouvaient demander des honoraires supplémentaires. Il n'est ainsi pas surprenant que dans les années 70, lorsque les gouvernements provinciaux ont commencé à réduire des tarifs d'honoraires médicaux, de plus en plus de médecins aient décidé de sortir du système. À la fin des années 70 et au début des années 80, on a connu un genre de reprivatization du système de santé. Beaucoup estimaient que le système public était chiche et voulaient travailler dans le secteur privé où ils avaient plus de liberté, une meilleure protection des revenus et plus de possibilités d'innovation.

Au début des années 80, nous constatons partout au pays de gros problèmes en ce qui concerne l'assurance-santé. Tellement de spécialistes avaient décidé de ne plus y participer, dans de grandes régions du pays, qu'il était impossible d'avoir accès à certains spécialistes tout en étant couvert par l'assurance-santé. C'était particulièrement vrai en obstétrique et gynécologie. La question d'accessibilité est devenue très importante. Le gouvernement Trudeau a finalement décidé que la seule façon de protéger le régime de santé public était de supprimer la possibilité d'offrir un service privé.

C'est essentiellement la décision qui a mené à la Loi canadienne sur la santé. Il y a diverses façons de formuler ceci. On peut y mettre des tas de connotations. L'État a décidé de garantir l'accessibilité au système en interdisant les soins de santé privés dans le contexte des services médicaux et hospitaliers essentiels. Autrement dit, la Loi canadienne sur la santé représentait un mur législatif qui créait un monopole d'État en matière d'assurance-santé. Le système semblait en effet voué inévitablement à l'échec sans ce genre de protection législative.

Nous avons depuis accumulé 16 ans d'expérience. Que s'est-il produit? La montée inexorable des coûts de santé a simplement continué. Les pressions sur le système d'État n'ont pas diminué. La protection offerte par la Loi canadienne sur la santé a permis d'imposer des contrôles des coûts dans le système d'État sans que cela suscite le genre de crainte que l'on avait connue dans les années 70 parce que les fournisseurs de soins ne pouvaient faire autrement.

Nous avons fait d'autres expériences de contrôle des coûts, la plus importante étant fondée sur la conviction de certains économistes spécialisés dans la santé que l'on peut réduire la demande en limitant l'offre de médecins et de personnel infirmier ainsi que d'autres fournisseurs de soins de santé. Vous entendrez certainement dire que la santé est un secteur étrange dans lequel les fournisseurs créent la demande. Si le système remet un diplôme à un nouveau médecin, il va se trouver des patients. Cela a mené à la décision au début des années 90 de limiter le nombre de médecins. Cette décision, parmi d'autres, mènera à d'énormes problèmes à l'avenir.

History does change. In the 1960s, we brought in private health care in an era when the state was seen as the collective instrument for solving our major social problems. We had great faith in the capacity of government in the 1960s. You will remember that we brought in the Canada Pension Plan at about the same time. The provinces were interested in automobile insurance. The state was moving to get user fees out of university education. We talked about the next step as the guaranteed annual income. That was an era of enormous optimism.

I suggest that, in the last 30 years, we have lost some of our faith in the capacity of the state to manage social issues, to manage problems, to manage enterprises, better than the private sector. In many areas of our social policy, we have agreed that the private sector has flexibility and nimbleness, and that market forces give signals and allocate resources more effectively than state planners can.

We have realized — and this is very important — that health care is, above all, about individuals taking responsibility for their own health. They cannot rely on their physicians to look after them. They cannot rely on anyone else. Fundamentally, health care is about individuals making decisions about their lives and their lifestyles.

At the end of the century we must face the question of whether we have taken the state approach to health insurance about as far as it can go. In the face of the ongoing and inexorable pressures, must we finally admit that our state monopoly and the problems entailed have become a hindrance to giving Canadians the full benefits of health science?

You have been getting political flak about the health care system in the last few years because Canadian citizens have decided that, in fact, it is the public health care system that is beginning to be a hindrance. When they go to hospitals or ER wards or to look for specialists, someone is getting in their way. That “someone” is increasingly seen to be the provincial ministries, the planners and the politicians who have been trying to put the brakes on spending and who will not allow a private alternative.

To fulfil the promises of the Hall Commission in the 1960s to minimize hindrances to health care, we must ask whether it is time to allow the entries into the private sector that will keep the system expanding and keep us doing the best we can in what is ultimately a Sisyphean task.

The Chairman: I want to thank the two of you for the both provocative and comprehensive overview.

Before turning to other senators, may I ask the two of you to respond to the last point raised by Professor Bliss? Tom Kent raised it in a different context when he made a distinction between what he called two-tier medical care versus separate medical care.

La situation évolue effectivement. Dans les années 60, nous avons introduit l'assurance-santé privée à une époque où l'État était considéré comme l'instrument collectif capable de résoudre nos grands problèmes sociaux. Dans les années 60, nous avions une foi énorme dans la capacité de l'État. Vous vous rappellerez que nous avons adopté le Régime de pensions du Canada à peu près au même moment. Les provinces s'intéressaient à l'assurance-automobile. L'État allait supprimer les droits d'inscription aux universités. On parlait même de la prochaine étape qui était le revenu annuel garanti. C'était une ère d'optimisme sans borne.

Je dirais qu'au cours des 30 dernières années, nous avons perdu une partie de cette confiance dans la capacité de l'État de gérer les problèmes sociaux, de gérer les problèmes en général, de gérer les entreprises, mieux que le secteur privé. Dans bien des secteurs de notre politique sociale, nous avons convenu que le secteur privé était plus souple et agile et que les forces du marché donnaient des signaux et déployaient les ressources plus efficacement que ne pouvaient le faire les planificateurs du secteur public.

Nous avons réalisé — c'est très important — que la santé, c'est avant tout obtenir que les gens prennent la responsabilité de leur propre santé. Ils ne doivent pas compter sur leur médecin pour s'occuper d'eux. Ils ne doivent pas compter sur personne d'autre. Fondamentalement, la santé, c'est laisser les gens décider de la vie qu'ils veulent mener et de leur style de vie.

À la fin du siècle, nous devons nous demander si nous avons poussé la formule d'assurance-santé publique jusqu'au bout. Face aux pressions constantes et inexorables, devons-nous finalement admettre que notre monopole d'État et les problèmes qu'il engendre empêche les Canadiens de profiter au maximum des sciences de la santé?

Vous avez été attaqués à propos du régime de santé public ces dernières années parce que les citoyens canadiens ont décidé qu'en fait c'est ce régime de santé public qui devient un obstacle. Quand ils vont à l'hôpital ou dans les salles d'urgence ou qu'ils veulent voir un spécialiste, il y a quelque chose qui bloque. Ce qui bloque semble de plus en plus être les ministères provinciaux, les planificateurs et les politiques qui essaient de freiner les dépenses et qui n'autorisent pas les services privés.

Si l'on veut respecter la recommandation de la Commission Hall des années 60 qui était de réduire au minimum les obstacles, nous devons nous demander s'il est temps d'ouvrir à nouveau la porte au secteur privé afin que le système puisse continuer à se développer et à nous permettre de faire le maximum dans le contexte d'une tâche de Sisyphe.

Le président: Je tiens à vous remercier tous les deux de cette bonne vue d'ensemble de la situation qui nous apporte ample matière à réflexion.

Avant de passer aux autres sénateurs, puis-je vous demander de répondre au dernier point soulevé par le professeur Bliss? Tom Kent l'a soulevé dans un contexte différent lorsqu'il a fait la distinction entre ce qu'il appelait un système à deux niveaux d'assurance-santé et un système offrant des soins distincts.

In light of the state monopoly that prevents opting out, essentially, is it possible to go from our present system to one that ensures accessibility regardless of income, as per the Canada Health Act objective, while at the same time increasing the flexibility described by Professor Bliss, and which Mr. Kent suggested might be possible?

The minute the question is raised about whether Canada can have a mixed public-private system, most witnesses will say that within a two-tiered system all the good doctors would go to the privately funded sector. Therefore, the quality of care would become a function of income. I am simplifying the argument, but that is what the argument is.

I wonder, Mr. Kent, if you wish to comment. First, do you think we need to go from the state monopoly to a more mixed system? If so, how do we get there while meeting the accessibility objectives of the Canada Health Act?

Mr. Kent: First of all, there are two distinct issues. In my view there can be no question of legislating out of existence a private sector, if people want to pay for the whole cost of health care for themselves and if they can find physicians and surgeons and so on willing to provide that health care at a cost that these, obviously by definition, relatively well-to-do people are prepared to pay. It is not a question of whether or not there should be a private sector. It is a question of whether it is possible to mix in operation the public health care with a system whereby people can buy extra services on top of what they get tax-financed, and, in effect, provided within the ambit of the public system. The answer to that, surely, is not, if you want, equal access unrelated to whether you have money in your pocket or not.

To look at the history, when the Liberal rally, in 1961, so firmly committed the Liberal Party to health care, it was with a provision. It was that the costs that an individual thereby incurred through the tax system, would indeed become a charge through the tax system directly to the individual. The value of the services that you obtained from public health insurance would become a part of your statement for income tax purposes, within limits, and so on, so that it would never be overwhelming in any one year for any individual or family, and it would mean that people who paid little or no tax would pay nothing for their health care, but people who had relatively large incomes, had a significant tax, would pay something.

That, if you like, is a mixing of private and public financing, which personally I very strongly supported at the time. It was never carried through. In other words, what I am saying is that I agree that there is not a rigid line between a complete state monopoly, entirely state financed and entirely tax financed, and, on the other hand, a private health insurance system.

The public health system can be made to work in conjunction with some different financial incentives, some user charges, provided that they are related to income, are not absolute amounts, and so on. Given the reality of the problems that Mr. Bliss spoke

Étant donné le monopole de l'État qui interdit de se retirer du système, à toutes fins pratiques, est-il possible de passer de notre système actuel à un système qui garantirait l'accessibilité aux services quel que soit le revenu, comme c'est l'objectif de la Loi canadienne sur la santé, tout en offrant davantage de souplesse comme semble le souhaiter le professeur Bliss et comme M. Kent semble le penser possible?

Dès que l'on demande si le Canada peut avoir un système mixte public-privé, la majorité des témoins répondent que dans un système à deux niveaux, tous les bons médecins choisiraient le secteur privé. Aussi, la qualité des soins deviendrait fonction du revenu. Je simplifie la chose mais c'est ainsi que se pose le problème.

Monsieur Kent, voudriez-vous préciser ce que vous nous avez dit? Tout d'abord, pensez-vous qu'il nous faille passer du monopole d'État à un système plus mixte? Dans l'affirmative, comment peut-on y parvenir tout en garantissant les objectifs d'accessibilité contenus dans la Loi canadienne sur la santé?

M. Kent: Tout d'abord, il y a là deux questions distinctes. À mon avis, il ne peut être question d'interdire dans la loi l'existence d'un secteur privé si les gens veulent payer eux-mêmes la totalité des services de santé et qu'ils peuvent trouver des médecins et des chirurgiens, et cetera, qui sont prêts à offrir ces services à un prix que ces gens-là, qui par définition sont évidemment des gens relativement aisés, sont prêts à payer. La question n'est pas de savoir si un secteur privé peut ou non exister. Ce qu'il faut savoir, c'est s'il est possible de faire fonctionner ensemble un système de santé public et un système qui permet aux gens d'acheter des services supplémentaires en plus de ce qu'ils peuvent obtenir dans le régime public et qui est en fait fourni dans le contexte du système public. C'est possible, mais à la condition de renoncer aux principes de l'universalité et de la gratuité.

Si l'on considère l'histoire, lorsque le rassemblement libéral de 1961 a tellement engagé le Parti libéral dans le sens d'un système de santé public, c'était à une condition. Que les coûts que devait ainsi encourir un citoyen dans le régime fiscal lui seraient imputés directement. La valeur des services obtenus grâce à l'assurance-santé publique entrerait dans la déclaration aux fins d'impôt, dans certaines limites, de sorte que cela ne deviendrait jamais trop pour un particulier ou une famille et que les gens qui payaient peu ou pas d'impôts n'auraient rien à payer pour les services de santé qu'ils recevaient mais que ceux qui avaient un revenu relativement important, payaient de lourds impôts, paieraient quelque chose.

C'est en quelques sortes un mélange de financement privé et public, auquel j'étais personnellement très favorable à l'époque. On ne l'a jamais réalisé. Autrement dit, ce que je dis, c'est que je suis d'accord pour qu'il n'y ait pas une démarcation rigide entre un monopole complet de l'État, un régime entièrement financé par l'État et par les impôts et, de l'autre côté, un régime privé d'assurance-santé.

On peut faire fonctionner le régime de santé public avec l'appui de divers stimulants financiers, avec un ticket modérateur, à condition que le montant soit proportionnel aux revenus, que ce ne soit pas un montant fixe, et cetera. Étant donné que M. Bliss a

about, that, arguably, health care by its nature is likely to cost more and more, just because of its success, certainly we must be flexible in devising ways of dealing with that situation.

The Ontario government has just taken one very sensible step in this direction, one that I have favoured for a long time, which is that we begin at least to qualify the fee-for-service principle by providing an extra incentive for doctors to practice in groups, which would do an enormous amount to take the strain off the hospital emergency system.

There is scope for a great deal of flexibility. I would repeat, though, that I do not think that you will get successful answers to that unless the federal government's recommitment to a share in the costs of this increasingly expensive system is reaffirmed.

Mr. Bliss: When you turn to the situation in other countries, you will find that most other countries in the world manage to have private and public systems coexisting, and you will soon quickly get beyond the bogeyman that the only alternative for Canada is the American system.

When you think about accessibility, and private and public, I urge you to think about what we do in public education. We have a wonderfully accessible public education system at the elementary and secondary levels. It is accessible to virtually all Canadians in every part of the country. It coexists in virtually every province with private options. It is my view that that is an extremely healthy coexistence because of the competition for excellence between private and public. If any province tried to outlaw private school systems, there would be a huge outcry of people complaining about their lack of freedom, but we have done this with health care.

It is fascinating that you ask the question of whether, if we have a private health care alternative, it will siphon off all the best personnel. When we write the history of health insurance in Canada, we will talk about the cadre of people who grew up in the 30 years after 1968 to defend the status quo, and the very large number of experts who began to have a vested interest in socialized medicine in Canada, and the skills with which they tried to argue against any change; and we will notice, for example, that whenever anybody suggested that privatizing some services would be useful, the health insurance establishment said, "This shouldn't be done, because private sector health care is far less efficient than public sector health care, because it has a profit motive, and so the public sector will be more efficient and more effective in every case."

On the other hand, when you propose allowing the private sector, the very same people reverse their argument and say we cannot allow the private sector because the private sector will become so effective and so efficient that the public sector will be starved. In other words, when it is useful for argumentative purposes, they say that in any competition the public sector would win, but then they reverse themselves and say the public sector cannot possibly compete with the private sector.

sans doute raison de dire que, de par sa nature même, la santé va coûter de plus en plus cher, précisément à cause des progrès qui se font, il faut certainement essayer de trouver des formules plus souples.

Le gouvernement de l'Ontario vient justement de prendre une initiative parfaitement raisonnable en ce sens, une initiative à laquelle je suis favorable depuis longtemps, et qui consiste à commencer à promouvoir le principe du ticket modérateur en donnant aux médecins une incitation supplémentaire à pratiquer en groupe, ce qui sera extrêmement utile pour réduire la pression sur les services d'urgence des hôpitaux.

La marge de manoeuvre est considérable. Je répète cependant qu'à mon avis, on n'obtiendra pas de réponses satisfaisantes tant que le gouvernement fédéral n'aura pas réaffirmé son engagement à assumer une partie des frais de ce régime de plus en plus coûteux.

M. Bliss: Si vous regardez ce qui se passe dans les autres pays, vous verrez qu'un peu partout dans le monde les régimes privés et publics coexistent, et vous vous rendrez rapidement compte que l'argument selon lequel la seule autre possibilité pour le Canada est de suivre le modèle américain est un argument bidon.

Si vous réfléchissez à la notion d'accessibilité et aux questions de secteur privé et public, pensez à ce que nous faisons dans le domaine de l'enseignement public. Nous avons un régime d'enseignement public extraordinairement accessible aux niveaux élémentaire et secondaire. Pratiquement tous les Canadiens y ont accès. Ce système coexiste avec des régimes privés dans pratiquement toutes les provinces. Je crois que c'est une coexistence extrêmement saine car le privé et le public se concurrencent pour être les meilleurs. Si une province essayait d'interdire les écoles privées, il y aurait un tollé et la population dénoncerait cette atteinte à sa liberté, mais c'est pourtant ce que nous avons fait dans le domaine de la santé.

Je trouve fascinant de vous entendre demander si un système privé de soins de santé n'entraînerait pas la fuite de tous les meilleurs éléments du système public. Quand on écrira l'histoire de l'assurance-santé au Canada, on parlera du groupe de personnes qui ont grandi dans les 30 années qui ont suivi 1968 pour défendre le statu quo, et du très grand nombre d'experts qui ont commencé à s'intéresser à la médecine sociale au Canada et des arguments qu'ils ont opposés à toute idée de changement; et on s'apercevra par exemple qu'à chaque fois que quelqu'un a proposé de privatiser des services, le bastion de l'assurance-santé a répondu: «Il ne faut pas le faire, car le secteur privé est beaucoup moins efficace que le secteur public en matière de soins de santé, parce qu'il est motivé par le profit, et par conséquent le secteur public est plus efficace en toute circonstance.»

D'un autre côté, quand on propose d'autoriser le secteur privé, les mêmes personnes se mettent à dire le contraire et affirment qu'il ne faut pas autoriser le secteur privé à fonctionner en parallèle avec le secteur public parce qu'il risque de devenir tellement efficace que le secteur public sera écrasé. Autrement dit, quand c'est utile pour leur argumentation, ils disent que le secteur public sera toujours meilleur que la concurrence, mais ensuite dans une autre situation ils se contredisent totalement et ils

Of course, the gem of truth in what they say is that we are still in the situation we were in back in 1983 or 1984, where, if you threw it open right now, a large number of medical personnel would move into the private sector to increase their incomes. The reason is that we have huge shortages of supply, because we have made absolutely the wrong planning decisions about health care personnel.

We bought a bill of goods from planners who thought they could read the market and the future and they have made ghastly mistakes in cutting back on the numbers of physicians and nurses — there is another problem with nurses — that will have enormous implications in the next few years. If we think things are bad now, they will get worse because of our shortages of supply.

I hesitate to use the words “flood the market,” but I do believe that the single most urgent need in the country is to produce more health care personnel to meet the demands of Canadians. If that means spending more money, spending more of our GNP on health care, that is fine. I have no problem with that.

We have made public and private systems work within education, partly because there are many teachers. They balance out. All the good teachers do not go into the private system. The public system has wonderful education. My children all benefited from the public system and got it for free. Why pay those extra fees if the public system works? The challenge in health care is to make the public system as good as any private system.

Senator Fairbairn: May I say that it is a treat to have both of you here. At this point in our hearings, not only are you giving us a much appreciated history lesson, but you are also getting right at some of the issues that clutter our minds going into this.

Mr. Kent said something to the effect that, if the public had its way, we would probably have changes more easily; we are now clearly in the grip, and coming from Alberta I feel in the grip, of the politics of federalism, which are very much involved in the situation in Alberta.

In this country we politicians have simplified our system when we deal with the public. We talk about medicare; we talk about the five principles and that we will live and die by them; but, if you are talking in terms of flexibility, that narrows it somewhat when you consider how much change has taken place, as you have said, Mr. Bliss, through drugs, through science, and everything else. We are no longer in quite as narrow a situation as we were back in the 1950s and 1960s, when this all began.

We often use the term “health care” rather than “medicare,” and that brings me to an element related to aging. I refer to the demographics of our aging society, which I do not believe

affirment qu’il n’est pas question que le secteur public puisse être en concurrence avec le secteur privé.

Le fond de vérité dans tout cela, c’est que nous en sommes encore au même point qu’en 1983 ou 1984, c’est-à-dire que si on ouvrait toute grande la porte, un grand nombre de personnes du secteur médical passeraient dans le privé pour augmenter leur revenu. Si nous avons de telles pénuries, c’est parce que nous avons fait complètement fausse route en matière de planification des effectifs de soins de santé.

Nous nous sommes faits raconter des histoires par des planificateurs qui croyaient connaître le marché et l’avenir et qui ont commis des bourdes colossales en réduisant le nombre de médecins et d’infirmières — il y a un autre problème avec les infirmières —, des erreurs qui auront des répercussions énormes dans les prochaines années. Si on a l’impression que cela va mal actuellement, il faut bien se dire que les choses ne vont qu’empirer à cause de cette pénurie.

J’hésite à parler «d’inonder le marché», mais je crois que le besoin le plus criant actuellement au Canada, c’est de produire plus de fournisseurs de soins de santé pour répondre à la demande. Si cela veut dire qu’il faut dépenser plus d’argent, consacrer une plus grande partie de notre PNB à la santé, très bien. Je n’ai aucune objection.

Nous avons réussi à faire fonctionner les régimes public et privé dans le domaine de l’enseignement en partie grâce à la présence de nombres importants d’enseignants. Ils s’équilibrent. Tous les enseignants ne vont pas nécessairement dans le privé. Le système public dispense un excellent enseignement. Mes enfants sont tous passés par les écoles publiques et ont bénéficié d’un enseignement gratuit. Pourquoi aller payer plus cher si le système public fonctionne? Le défi dans le domaine de la santé, c’est de faire en sorte que le régime public soit aussi bon que le régime privé.

Le sénateur Fairbairn: Je dois dire que c’est un plaisir de vous entendre tous les deux. À ce stade de nos audiences, non seulement vous nous donnez une leçon d’histoire fort judicieuse, mais vous allez au coeur de certaines des questions avec lesquelles nous nous débattons.

M. Kent a dit que si le public pouvait faire ce qu’il voulait, les choses changeraient probablement plus facilement; il est clair que nous sommes englués, et venant de l’Alberta, je me sens moi-même engluée, dans la politique de fédéralisme, qui pèse beaucoup sur la situation en Alberta.

Au Canada, nous autres les politiciens, nous avons simplifié notre régime de relations avec le public. Nous parlons d’assurance-maladie; nous parlons des cinq principes que nous nous engageons à respecter absolument; mais quand on parle de souplesse, les choses se rétrécissent compte tenu de tous les changements qui se sont produits, comme vous l’avez dit, monsieur Bliss, dans le domaine des médicaments, de la science et partout ailleurs. La situation est beaucoup moins délimitée qu’à l’époque des années 50 et 60, quand tout cela a commencé.

On parle souvent de «soins de santé» plutôt que «d’assurance-maladie», et cela me fait penser à la question du vieillissement. Nous avons une société vieillissante, et je crois que

governments anywhere in this country have done anything to plan for in the last many years, when it has been very obvious. In respect of the health system, no longer do we just go to the doctor, get diagnosed, go to the hospital, get dealt with and then that is it. It is not that way any more. Now you go home. That makes that part of the health care system for Canadians absolutely fundamental and critical.

Mr. Kent, you said that you thought that it would be a disaster to split off home care, and have it settled with separate bags of money on its own. I personally would agree with that. The problem is that along the way we have failed, I think, to put in the connecting links that make home care part of the overall health care dimension.

I wonder if the two of you could comment on that, because it is something that we have already been hearing from witnesses, that that end piece, so to speak, is very scary. Perhaps that is one of the reasons why the public, although they may not want state monopoly on all of this, are often not looking at their provincial governments, when they become afraid, but are looking at the federal government for reassurance and some vision on this. I would like to have your comments on that.

Mr. Kent: The only way to deliver health care both fairly, with access and so on, and efficiently is to organize it at a community level, with a coordinating responsibility in a health organization area, which is responsible for the allocation of resources to the various forms of services, including home care, most definitely.

I agree that we have under-provided ourselves with doctors and so on, but what we have above all under-provided ourselves with are nurses. It is the role of the nurse in community care that probably is really the worst feature of our health system, at the moment. It is also important that the medical profession, in the narrow sense, play a major role in that community arrangement, and that services be available on a community basis 24 hours a day, seven days a week, at the home and office level, on the telephone, and, above all, now. People should not need to go to the emergency ward of a hospital whenever they think there is something wrong with them.

The thing must work as a whole if it is to be efficient. Looking after health is not just health care. It is the prevention of foolish activities, of ill health, as far as one can, and influence against them. It is essential, I say again, that that be seen as a whole and not as some separate services for home care or this, that and the other. We made that mistake in the hospitals. We made it for understandable reasons, but it was a great mistake.

I should like to talk, if the opportunity arises, a little bit about the relationship of this to the public-private mix, but that is separate from your direct question, and I hope I have responded to that.

The Chairman: Go ahead and make your comment, because I was going to ask you a question about the public-private mix in any event. Go ahead, and then we will turn to Mr. Bliss.

les gouvernements n'ont rien fait pour s'y préparer depuis de nombreuses années, alors que c'était évident. En matière de santé, on ne va plus simplement chez le docteur pour obtenir un diagnostic, on ne va plus simplement à l'hôpital pour régler un problème. C'est fini, cela. Maintenant, on va à la maison. Cet aspect du régime de soins de santé est donc absolument fondamental pour les Canadiens.

Monsieur Kent, vous avez dit que ce serait une tragédie de séparer les soins à domicile, d'avoir un financement distinct pour ce genre de soins. Je suis personnellement d'accord. Le problème, c'est qu'à mon avis nous n'avons pas su intégrer ces soins à domicile au régime d'ensemble des soins de santé.

Pourriez-vous m'en parler un peu tous les deux, car plusieurs témoins nous en ont déjà parlé, et nous ont présenté une vision assez terrifiante de cet aspect de la question. C'est peut-être pour cela que le public, bien qu'il ne souhaite pas que l'État ait le monopole de tout cela, ne se tourne tout de même pas vers les gouvernements provinciaux quand il commence à avoir peur, mais se tourne au contraire vers le gouvernement fédéral pour se rassurer et essayer d'avoir une vision d'avenir là-dessus. J'aimerais savoir ce que vous en pensez.

M. Kent: La seule façon d'assurer une prestation des soins de santé qui soit à la fois équitable, accessible et efficace consiste à l'organiser à un niveau communautaire, l'organisme de santé de la région étant responsable de l'allocation des ressources ou diverses formes de services, notamment les services de soins à domicile.

Je conviens que nous n'ayons pas suffisamment de médecins, mais ce dont nous manquons surtout, ce sont d'infirmières. À l'heure actuelle, le pire élément de notre régime de santé est sans doute le rôle que jouent les infirmières dans les soins communautaires. Il est par ailleurs important que la profession médicale, au sens étroit du terme, joue un rôle important au niveau communautaire et que les services soient offerts sur une base communautaire 24 heures sur 24, sept jours sur sept, au bureau et à domicile, au téléphone, et par-dessus tout, immédiatement. Les gens ne devraient pas être obligés de se rendre à l'urgence d'un hôpital lorsqu'ils pensent qu'il y a quelque chose qui ne va pas.

Pour être efficace, le système doit fonctionner comme un tout. La promotion de la santé va au-delà des soins de santé. Dans la mesure du possible, il faut faire un travail de prévention contre la mauvaise santé et les habitudes qui peuvent en être la cause. Je répète qu'il est essentiel de considérer cela comme un tout, non pas comme des services distincts pour des soins à domicile ou autre chose. Nous avons commis cette erreur dans les hôpitaux. Nous avons commis une erreur pour des raisons que l'on peut comprendre, mais c'était une grave erreur.

Si j'en ai l'occasion, j'aimerais parler un peu du rapport de tout cela avec la prestation publique et privée des soins de santé, mais cela n'a pas un lien direct avec votre question, et j'espère y avoir répondu.

Le président: Allez-y, faites votre observation, car j'allais justement vous poser une question à ce sujet de toute façon. Allez-y, nous donnerons ensuite la parole à M. Bliss.

Mr. Kent: I would first say to Mr. Bliss that certainly there is a public-private mix in education, but if you choose to send your sons to Upper Canada College, you do not get any tax help for that.

Mr. Bliss: Yes.

Mr. Kent: I do not know how anyone could oppose separate system in that sense. In our sort of society, nobody is going to say that, so long as some people are very much better off than others, then those who are very much better off should not be free to buy their own health care, their own education for their kids, or whatever they want. That is not the issue.

The issue is whether, given that we have, have chosen to have, and are going to maintain in some form, a public system essentially, then that public system in itself must be entirely tax financed — not financed by a mixture of tax financing with add-ons that you can buy as an individual if you can afford them. If you do that, then you will bleed the provision for people who cannot afford the add-ons, because there is just no avoiding the fact that, if you have the two-tier system, then certainly the resources of doctors and so on are going to be bled off from the public system. It is just absolutely unavoidable. If you give extra care to some people for a fee, then there are going to be fewer doctors and fewer nurses working for the people who cannot afford those extra fees.

If we had lots of doctors and lots of nurses, obviously this would not be a serious problem. However, we do not, and we are not going to be able to afford them. Certainly we will need to continue to spend somewhat more of our GNP on health, probably, but we want to limit the extent to which that happens.

I would say again that the type of user fee related to income through the tax system that many of us suggested four years or something ago, is a desirable feature of the system. It is a pity that it was never incorporated. We certainly provided that the assurance of federal support is there, and it ought to be possible to agree on a more flexible, in some respects, and a narrower range of services to be included in the definition of “comprehensive care.” Certainly, there have been things done within the tax finance system that ought never to have been done — cosmetic surgery and so on.

There is ample room for improving a public system without in any way jeopardizing the existence of a private system, if people want to have it and can afford to have it. Some people will work in such a system, but you cannot mix the public system with user charges made as a condition of service, as distinct from some recovery through the tax system, which is a very different way of doing things.

Mr. Bliss: In respect of the private system, if some of us wanted to found the health care equivalent of an Upper Canada College, such as a private hospital that offered emergency services, and we wanted to be free to charge anything we liked, in most parts of Canada that would be illegal because of the constraints imposed on the provinces by the Canada Health Act.

M. Kent: Je dois dire d’abord à M. Bliss que dans le domaine de l’éducation, il y a des écoles publiques et des écoles privées, mais si vous choisissez d’envoyer vos fils à Upper Canada College, vous ne recevrez aucune aide fiscale.

M. Bliss: Oui.

M. Kent: Je ne sais pas comment quiconque pourrait s’opposer à un système distinct en ce sens. Dans une société comme la nôtre, personne ne dira que ceux qui sont beaucoup plus riches que d’autres ne devraient pas être libres d’acheter leurs propres soins de santé, des cours privés pour leurs enfants ou quoi que ce soit d’autre qu’ils souhaitent acheter. Là n’est pas la question.

Il s’agit plutôt de décider si le régime que nous avons, que nous avons choisi d’avoir et que nous allons maintenir sous une certaine forme, qui est essentiellement un régime public, doit être entièrement financé par les impôts — non pas par un mélange d’impôts avec des ajouts qu’il est possible d’imposer lorsqu’une personne en a les moyens. Si on a un tel système, ce sera alors au détriment des gens qui n’ont pas les moyens de se payer des services complémentaires, car on ne peut tout simplement pas éviter le fait que si l’on a un régime à deux niveaux, cela va certainement drainer du régime public certaines ressources, notamment les médecins. Cela est tout simplement inévitable. Si les gens peuvent recevoir des soins supplémentaires en payant, il y aura moins de médecins et moins d’infirmières qui travaillent pour ceux qui n’ont pas les moyens de déboursier un montant supplémentaire.

S’il y avait suffisamment de médecins et d’infirmières, cela ne serait évidemment pas un problème grave. Ce n’est cependant pas le cas et nous n’aurons pas les moyens de les payer. Nous devons certainement continuer de dépenser un pourcentage plus élevé de notre PIB pour la santé mais toutefois d’une façon limitée.

Je tiens à répéter que le type de frais modérateurs en fonction du revenu dans le cadre du régime fiscal que bon nombre d’entre nous ont proposé il y a quatre ans environ est un élément qu’il serait souhaitable d’intégrer au régime. C’est dommage qu’on ne l’ait jamais intégré au régime. Nous avons certainement assuré l’appui fédéral ici, et il devrait être possible de s’entendre sur une gamme plus étroite, une gamme plus souple, à certains égards, de services à inclure dans la définition de «soins de santé intégrés». Il y a certainement des services qui n’auraient jamais dû être couverts par le régime public de soins de santé — notamment la chirurgie esthétique, et cetera.

Il est tout à fait possible d’améliorer un régime public sans compromettre de quelque façon que ce soit l’existence d’un régime privé, si les gens veulent avoir un tel régime et s’ils en ont les moyens. Certaines personnes travailleront pour un tel régime, mais il n’est pas possible d’ajouter au régime public des frais modérateurs comme condition de service, ce qui est très différent du recouvrement des frais par le régime fiscal.

M. Bliss: En ce qui concerne le régime privé, si certains d’entre nous veulent mettre sur pied un régime de soins de santé équivalent à un Upper Canada College, notamment un hôpital privé qui offrirait des services d’urgence et que nous voulions être libres de demander ce que nous voulions pour de tels services, dans la plupart des régions du Canada ce serait illégal en raison

We, in Canada in 1984, outlawed health care acts between consenting adults. I think it was a remarkable limitation on the freedom of our people and only the doctors realized what was happening, but they were so discredited for so many other reasons that nobody paid them any attention.

Here is where there may be a fundamental disagreement with Mr. Kent. When I listen to him, I detect the "planner's" ambivalence — the same ambivalence that the current government has displayed: "There is a problem with the system. It is not working properly. How do we fix it?" There is a temptation, when a planner is faced with a problem, to suggest that the answer is: "We have to extend our control." Therefore, in health care, since the system is in trouble, perhaps we should expand health care into home care, and into pharmacare, because in that way we could have more and more control over the whole system. It is the same problem that the price controllers ran into during the war and again in the 1970s — that you just have to keep expanding your reach because otherwise you get nibbled away.

If we have learned anything about socialist economics, socialized planning, and planning in general in the 20th century, it is that this is a mug's game. It does not work. In Canada, some people are saying, "Well, we should take over pharmacare and put this all on a managed, administered basis." In effect, what they are suggesting is that it be turned over to the same people who are currently failing to plan the current system, on the assumption that somehow they will get it right the next time. I say that, if we have learned anything in the 20th century about managing economies, it is that we have to go the other direction and let market forces operate as best we can.

It is scary, yes, it is scary. The problem is that old age and death are scary. We have ourselves impaled on the fear dilemma. Whenever we talk about trying to change the way we organize and fund our system, many of our citizens, and you can perfectly understand it, get worried that they will not be able to get health care.

It is easy to understand the exasperation of Mr. Klein because of the protests that he has faced. He feels that he is trying to improve things, but people are frightened. That is a very powerful problem and there are no easy answers to it.

Senator Carstairs: Because people are watching on television, I think it is important that we make sure that there are some clear facts here. While there isn't any public funding to attend Upper Canada College, there is public funding to attend St. John's Ravenscourt School in Winnipeg; 50 cent dollars is what you get in that province.

Mr. Bliss: They pay to go where?

Senator Carstairs: St. John's Ravenscourt in Winnipeg, which is the equivalent private school, I would suggest, to Upper Canada College. There is, then, that mix out there within the

des contraintes imposées aux provinces par la Loi canadienne sur la santé. Au Canada, en 1984, nous avons interdit les actes de soins de santé entre adultes consentants. Je pense que cela a été une restriction remarquable de la liberté des Canadiens et seuls les médecins se sont rendus compte de ce qui se passait, mais ils ont été tellement discrédités pour de nombreuses autres raisons que personne ne leur a accordé d'attention.

C'est peut-être ici que je ne suis pas du tout d'accord avec M. Kent. Lorsque je l'écoute, je décèle l'ambivalence du «planificateur fermé» — la même ambivalence que ressent le gouvernement à l'heure actuelle: «Il existe un problème dans le régime actuel. Il ne fonctionne pas bien. Comment pouvons-nous régler ce problème?» Lorsqu'il se retrouve devant un problème, le planificateur est tenté de donner la réponse suivante: «Nous devons étendre notre contrôle.» Par conséquent, puisque le régime de soins de santé connaît des difficultés, nous devrions peut-être étendre les soins de santé aux soins à domicile, à l'assurance-médicaments, car de cette façon nous aurions de plus en plus de contrôle sur tout le régime. Ceux qui contrôlaient les prix ont eu exactement le même problème pendant la guerre et à nouveau pendant les années 70 — constamment étendre la portée du régime sinon il risque de se faire gruger petit à petit.

S'il y a une chose que nous ont apprise les économies socialistes, la planification socialisée et la planification en général au XX^e siècle, c'est bien qu'on se fait toujours avoir. Cela ne fonctionne pas. Au Canada, il y a des gens qui disent: «Eh bien, nous devrions prendre le contrôle de l'assurance-médicaments dans le cadre d'un régime administré, géré.» En effet, ce qu'ils proposent, c'est que l'on confie l'administration de ce régime aux mêmes personnes qui à l'heure actuelle n'arrivent pas à planifier le régime actuel, en supposant qu'ils réussiront on ne sait trop comment la prochaine fois. Je dis que si nous avons appris quoi que ce soit au XX^e siècle, c'est que nous devons aller dans l'autre direction et laisser dans la mesure du possible les forces du marché faire leur travail.

Oui, cela fait peur. Le problème, c'est que le vieillissement et la mort font peur. Nous sommes partagés devant le dilemme de la crainte. Chaque fois que nous tentons de changer notre façon de nous organiser et de financer notre régime, bon nombre de nos citoyens, ce qui est tout à fait compréhensible, s'inquiètent qu'ils n'auront pas accès à des soins de santé.

Il est facile de comprendre l'exaspération de M. Klein en raison des protestations auxquelles il a dû faire face. Il estime qu'il tente d'améliorer les choses, mais les gens ont peur. Il s'agit là d'un problème très puissant et il n'y a pas de réponses faciles.

Le sénateur Carstairs: Étant donné que les gens nous regardent à la télévision, je pense qu'il est important de nous assurer que les faits sont clairs ici. Upper Canada College ne bénéficie peut-être pas de financement public, mais ce n'est pas le cas de l'école St. John's Ravenscourt à Winnipeg qui est financée à 50 p. 100 par le secteur public dans cette province.

M. Bliss: Quelle école?

Le sénateur Carstairs: St. John's Ravenscourt à Winnipeg, une école privée qui, je dirais, est l'équivalent de Upper Canada College. Il existe donc ce mélange dans le système scolaire

public-private school system. However, I would carry that analogy a little further, because we have a growing private school system in Canada, and it is growing faster than the public school system, I would suggest, because people feel frustrated with the public system. People feel frustrated with the public system in Manitoba because the fastest growing expenditure in the province in education is not for textbooks, but is for busing.

The second highest expenditure growth, in terms of percentage, is for special needs students. Those students used to be paid for out of the social service budget, but now they are being paid for out of the education budget. We have an increasing number of youngsters who have attention deficit disorder and are now in the public school system. Parents are saying, "I don't want my child in that class, so I am going to move into the private school system."

With respect to health care, what concerns me, therefore, is that, if there is an attempt to mix the two health care systems, people will be driven into the private system. I would suggest that that will lend a deteriorating quality to the public system.

My understanding of the Canada Health Act is that there could be private hospitals in Canada, provided that they did not receive public monies and provided that the doctors working in those private facilities did not take any public patients; if they wanted to opt out and not accept any government money whatsoever, they could, in fact, continue to function, even under the Canada Health Act.

Mr. Bliss: Perhaps that is so in Manitoba. My understanding of Ontario and other provinces is that their fees would be fixed at the same levels as the public system compensates for. They could not charge above a certain level.

Mr. Kent: I will comment on that, if I may. We must be clear that the ultimate responsibility for the education system and the health system lies with the individual province. Many provinces do, in fact, effectively prohibit a separate, private health system, just as those provinces also ensure that the private education system is entirely private, and does not get public subsidies, which is the situation in Ontario.

The situation in this respect is not, as I understand it, legally the consequence of the Canada Health Act. There is nothing in the Canada Health Act that in itself prohibits separate, private medicine. What is prohibited, and in my view certainly should remain prohibited, is the mixing of the two. A mixing of the two would be disastrous for the accessibility, the quality, and the efficiency of the public health system.

The Chairman: Why? You make a categorical statement that the mixing of the two would be disastrous for the public sector. What is the evidence for that statement? What logic leads you to that conclusion?

public-privé. Cependant, je porterais cette analogie un peu plus loin, car nous avons au Canada un système scolaire privé qui est en train de se développer beaucoup plus rapidement que le système scolaire public car les gens sont mécontents du système public. Les gens sont mécontents du système public au Manitoba parce que dans cette province, là où les dépenses augmentent le plus, ce n'est pas pour les manuels scolaires, mais pour le transport des élèves.

La deuxième catégorie de dépense qui augmente le plus, en pourcentage, est celle liée à l'enseignement à l'enfance en difficulté. Auparavant, ces dépenses étaient payées à même le budget des services sociaux, mais elles sont maintenant payées à même le budget d'éducation. Il y a un nombre croissant de jeunes qui souffrent d'un trouble déficitaire de l'attention et qui sont maintenant dans le système scolaire public. Les parents disent: «Je ne veux pas voir mon enfant dans cette classe, alors je vais l'envoyer dans une école privée.»

En ce qui concerne les soins de santé, ce qui me préoccupe donc, c'est que si on tente de mélanger les deux régimes de soins de santé, les gens se sentiront obligés de recourir au régime privé. Je dirais que cela mènera à une détérioration de la qualité du régime public.

Si je comprends bien la Loi canadienne sur la santé, il peut y avoir des hôpitaux privés au Canada, pourvu qu'ils ne reçoivent pas des fonds publics et que les médecins qui y travaillent ne prennent pas des patients du régime public; s'ils choisissent de ne pas participer au régime public et de ne pas accepter l'argent du gouvernement, ils pourraient en fait continuer de fonctionner, même aux termes de la Loi canadienne sur la santé.

M. Bliss: C'est peut-être le cas au Manitoba. Pour l'Ontario et les autres provinces, je crois comprendre que les frais seraient établis au même niveau que ceux qui sont indemnisés par le régime public. Les frais demandés ne pourraient dépasser un certain niveau.

M. Kent: J'aimerais faire des observations à ce sujet, si vous me le permettez. Qu'il soit bien clair que chaque province est responsable en fin de compte du système d'éducation et du régime de santé. Bon nombre de provinces interdisent en fait tout régime de soins de santé privé et séparé, tout comme ces provinces s'assurent également que le système d'enseignement privé est entièrement privé et ne reçoit aucune subvention publique, ce qui est le cas en Ontario.

Si j'ai bien compris, cette situation n'est pas légalement la conséquence de la Loi canadienne sur la santé. Il n'y a rien dans la Loi canadienne sur la santé comme telle qui interdit une médecine privée, séparée. Ce qui est interdit, et ce qui à mon avis devrait certainement rester interdit, c'est que l'on mélange les deux. Un mélange des deux serait désastreux pour l'accessibilité, la qualité et l'efficacité du régime de santé public.

Le président: Pourquoi? Vous déclarez catégoriquement que le mélange des deux serait désastreux pour le secteur public. Quelle preuve en avez-vous? Quelle logique vous permet d'en arriver à cette conclusion?

Mr. Kent: We are clear that we are talking about two-tier medicine, as I define it: that is to say, there is an extra charge that is paid directly to the physician, or whatever, for services additional to those non-insured services, although the insured services remain entirely tax financed.

Let's take a concrete example: a patient can have a cataract operation, a lens replacement, within the public system entirely tax financed. However, in the private eye clinics that have developed, you can get what is alleged to be a better quality lens, provided you pay \$200, \$300 or \$400 for it. If we make it financially attractive to the doctor who is practising within the public system to provide additional services for an extra fee, obviously he will pay more attention to those opportunities than he would to the work within the public system.

We all know that most doctors work very hard. We also know that there are lazy doctors who do very well without working very hard within the public system. If there is an incentive and we are able to combine the two, then clearly the quality of effort within the public system will deteriorate. That is a dogmatic statement, but it is also an obvious one. How can one not be dogmatic on that point?

Mr. Bliss: There are other ways of establishing the mix. The University of Toronto is a mixed public-private institution that takes in money both ways. However, I can see some of Mr. Kent's arguments.

The education model and what Senator Carstairs said is interesting. In most provinces, those systems have managed to coexist for 100 years, so that if we have problems now, we may find ways to work them out. People in education are now saying that perhaps the way to resolve the public-private split is to go to vouchers in which the state, in effect, gives people money and they decide which schools they favour. Of course, the Americans are experimenting with this in a tremendous way.

The health care equivalent of vouchers appears to be the medical savings accounts that people are talking about. On this very evening, David Gratzer will be getting the Donner prize for public policy for his book *Code Blue: Reviving Canada's Health Care System*, which advocates medical savings accounts. I read it on the way up here this morning. It is an interesting and fascinating idea. I hope your committee will study the new ideas in the book because they may help us through our dilemmas.

Senator Carstairs: Interestingly enough, he is a graduate of a private school, St. John's-Ravenscourt. Perhaps that has something to do with his overall view of how society should work.

Mr. Bliss: I just assumed creative ideas come out of Manitoba.

Senator Carstairs: My question to you, Mr. Bliss, has mainly to do with your statement, which I think is absolutely correct, that some planner made a decision that we had too many physicians and, therefore, we should cut the number of doctors being trained in our medical schools. When I went back and reviewed the

M. Kent: Il est clair que nous parlons ici d'un régime de soins de santé à deux niveaux, tel que je le définis: c'est-à-dire que des frais supplémentaires sont versés directement aux médecins ou autres pour des services supplémentaires qui ne sont pas assurés, même si les services assurés demeurent entièrement financés par les impôts.

Prenons un exemple concret: un patient peut subir une chirurgie de la cataracte, faire remplacer ses verres pour aphaques, et tout cela est entièrement financé par le régime public. Cependant, dans une clinique privée pour la vue, il est maintenant possible d'obtenir des verres censés être de meilleure qualité si l'on est prêt à payer 200 \$, 300 \$ ou 400 \$. Si nous faisons en sorte qu'il est financièrement intéressant pour le médecin qui pratique dans le régime public d'offrir des services additionnels pour un montant supplémentaire, naturellement il sera davantage porté à offrir de tels services que de faire le travail dans le cadre du régime public.

Nous savons tous que les médecins travaillent très fort. Nous savons également qu'il y a des médecins paresseux qui réussissent très bien sans travailler très fort dans le régime public. S'il y a un incitatif et que nous pouvons combiner les deux, alors il est clair que la qualité de l'effort dans le régime public se détériorera. C'est une déclaration dogmatique, mais c'est également évident. Comment ne peut-on pas être dogmatique là-dessus?

M. Bliss: Il y a d'autres façons de mettre sur pied un système mixte. L'Université de Toronto est une institution mixte publique et privée qui reçoit de l'argent des deux côtés. Cependant, je peux comprendre certains des arguments de M. Kent.

Le modèle du système d'enseignement et ce qu'a dit le sénateur Carstairs sont des choses intéressantes. Dans la plupart des provinces, ces systèmes ont réussi à coexister pendant 100 ans, de sorte que si nous avons des problèmes à l'heure actuelle, nous pourrions peut-être trouver des solutions. Les gens dans l'enseignement disent actuellement que la solution consiste peut-être à remettre aux gens des bons qu'ils pourront utiliser pour des écoles publiques ou des écoles privées selon leur choix. Bien sûr, c'est un système qui est très répandu aux États-Unis.

Dans le régime de soins de santé, l'équivalent des bons semble être les comptes d'épargne médicaux dont les gens parlent. Ce soir même, David Gratzer recevra le prix Donner pour son livre intitulé *Code Blue: Reviving Canada's Health Care System*, qui préconise les comptes d'épargne médicaux. Je le lisais ce matin en venant ici. Il s'agit d'une idée intéressante et fascinante. J'espère que votre comité examinera les nouvelles idées contenues dans ce livre car cela pourra nous aider à régler nos dilemmes.

Le sénateur Carstairs: Ce qui est intéressant, c'est qu'il est diplômé d'une école privée. St. John's-Ravenscourt. Cela a peut-être quelque chose à voir avec ses idées générales sur la façon dont la société devrait fonctionner.

M. Bliss: Je supposais tout simplement que de telles idées créatrices sont le propre du Manitoba.

Le sénateur Carstairs: La question que je voudrais vous poser, monsieur Bliss, est essentiellement la suivante: vous avez déclaré, et je pense que vous avez tout à fait raison, qu'un planificateur a décidé qu'il y avait trop de médecins et que par conséquent nous devrions réduire le nombre de médecins qui sont formés dans nos

so-called planning argument, it was that at the same time we would change the way in which health care was delivered. We would introduce a system of nurse practitioners who could then pick up those things that doctors do that quite frankly they do not need to do. For example, they do not need to give inoculations, nor do they need to do 90 per cent of the blood pressure readings, and so on.

Why is it that we look at a planning document such as that and leap into the simple solution offered, but we never seem to look at all of the other recommendations the planner has made in order to make that simple solution work?

Mr. Bliss: Again, that is the planner saying, "You have to buy the whole package. If one think in it goes, then, sorry, the whole thing is done and it is not my fault."

When you talk about nurse practitioners, you raise a whole raft of other issues that are nicely summarized in your assumption that the planners could tell us what we needed. We do not need these things. This is the 21st century. Who will tell me what my health care needs are? Who will tell my wife and my children? Surely, in one of the wealthiest societies the world has ever known, for a bunch of planners to say that they will give us medical personnel who are not as well trained — that is, nurse practitioners — because they do not think we have the needs that we think we do is a recipe for impossibility. People in a modern society simply will not accept that. Again, that is part of the notion that planners can tell us our health care needs and tell us that we are overusing the system.

Anyone who knows the dynamics of illness and the relationship between patients and physicians knows that the system is so much more complicated than the health care economists can begin to understand. We have made huge mistakes and have been misled by the people who say, "You do not need these things." Historically, it is particularly ironic because one of the rationales for the introduction of first-dollar health insurance was to get people to go to their physicians more often. The evidence was that when we put financial barriers in the way, people would not go when they really needed to go. As soon as those barriers were removed and the people started going to the doctor, then there were complaints that they were going when they did not need to go. That is the problem. The planner's world rests on all sorts of assumptions. If one turns out to be wrong, then we have got ourselves into a mess.

écoles de médecine. Lorsque j'ai vérifié le soi-disant argument de planification, j'ai constaté que nous voulions en même temps changer la façon d'offrir les soins de santé. Nous voulions introduire un régime de soins infirmiers de première ligne où les infirmiers et infirmières pourraient s'occuper de certaines choses que les médecins ne sont franchement pas obligés de faire. Par exemple, ils ne sont pas obligés de faire les inoculations, ni de prendre la tension artérielle dans 90 p. 100 des cas, et cetera.

Pourquoi ne pouvons-nous pas prendre ce document de planification et voir au-delà de la simple solution offerte, car il semble que nous ne tenions pas compte de toutes les autres recommandations que le planificateur a faites pour faire en sorte que cette solution simple puisse fonctionner?

M. Bliss: Encore une fois, c'est le planificateur qui dit: «Il faut accepter toute la proposition. Si le moindre élément n'est pas accepté, alors désolé, cela ne peut fonctionner et ce n'est pas ma faute.»

Lorsque vous parlez de soins infirmiers de première ligne, vous soulevez toute une série d'autres questions qui sont bien résumées lorsque vous supposez que les planificateurs pourraient nous dire ce dont nous avons besoin. Nous n'avons pas besoin de ces choses. Nous sommes au XXI^e siècle. Qui va me dire quels sont mes besoins en matière de soins de santé? Qui va dire cela à ma femme et à mes enfants? Certainement, dans l'une des sociétés les plus riches que le monde ait jamais connues, qu'un groupe de planificateurs disent qu'ils vont nous donner un personnel médical qui est moins bien formé — c'est-à-dire des infirmiers et infirmières de première ligne —, car ils ne pensent pas que nous ayons les besoins que nous pensons avoir, est une méthode vouée à l'échec. Dans une société moderne, les gens ne peuvent tout simplement pas accepter une telle chose. Encore une fois, cela fait partie de la notion selon laquelle les planificateurs peuvent nous dire quels sont nos besoins en matière de soins de santé et nous dire que nous surutilisons le régime.

Quiconque connaît la dynamique de la maladie et des rapports entre les patients et les médecins sait que le régime est beaucoup plus compliqué que ce que les économistes en matière de soins de santé peuvent comprendre. Nous avons commis d'énormes erreurs et nous avons été induits en erreur par les gens qui disent: «Vous n'avez pas besoin de ces choses.» D'un point de vue historique, c'est une situation particulièrement paradoxale car l'une des raisons pour lesquelles le programme national d'assurance-maladie sans franchise a été introduit, c'était pour que les gens aillent voir leur médecin plus souvent car, lorsqu'on leur impose des obstacles financiers, les gens ne vont pas voir leur médecin alors qu'ils auraient vraiment besoin d'y aller. Dès que ces obstacles ont été éliminés et que les gens ont commencé à aller chez le médecin, alors on a commencé à dire qu'ils y allaient alors qu'ils n'en avaient pas besoin. Voilà le problème. Ce que propose le planificateur est fondé sur toutes sortes de suppositions. S'il y en a une qui est erronée, alors nous nous retrouvons dans un véritable bourbier.

[Translation]

Senator Gill: Sixty years ago, universality became necessary for some systems. A little later, it was decided to provide amounts for old-age security, and a great deal has been done in this regard.

It seems to me that there was a lack of information, that people did not know that some services existed. We have established systems, structures and administrations. Over time, a number of steps between the patient and the care required increased. Today, people have to go through a number of steps before they get a service.

Given this, why not proceed as is being done in education, where everything is now accessible? If people need help, they get help through the tax system or through scholarships.

There are no longer any limits on the health care system, and we have to find some solutions. The solutions should enable people to make decisions about their own health care and get financial assistance if they need it.

The health care system should be more tailored to individual needs. We should try to find ways of giving people access to health care services in somewhat the same way as is done in education.

[English]

Mr. Bliss: I agree with everything you have just said, senator. Yes, we must individualize the system. The model of education is an interesting one, as is the model of other countries that have experimented with a public-private mix. We must get away from our obsession with the United States, where they have a set of particular problems. We do not need to go down the American route. There are other ways we can go. I do not know whether Scandinavia is still the way to go, or whether we should look to our friends in New Zealand, Australia, France or Germany. Unfortunately, Britain is a poorer society than Canada, and their public-private balance still does not seem to work properly.

Mr. Kent: Most people do not make market decisions, and never have made market decisions about health care. They do not know enough about what it is that they are buying. They are dependent on the view of physicians and health care advisers. If they had to pay those advisers, they did not go to them if they could not afford it. If they do not have to pay, they do go.

The issue is not that I or Michael Bliss or anybody is in a position of choosing what he should have as a health care, making his own decisions about health care. People need a health care system of some kind to go to. The issue is whether or not the access to that system, whether you call it a market system or a public system, is provided on some organized basis.

[Français]

Le sénateur Gill: Il y a 60 ans, l'universalité de certains systèmes était devenue nécessaire. Un peu plus tard on a décidé d'accorder des montants d'argent pour la sécurité de la vieillesse, et beaucoup a été fait en ce sens.

J'ai l'impression qu'il y avait un manque d'information, les gens n'étaient pas au courant de l'existence de certains services. On a créé des systèmes, des structures et des administrations. Avec le temps, différentes étapes entre le patient et les soins qu'il demandait se sont ajoutées. Aujourd'hui on doit passer à travers plusieurs étapes avant de pouvoir bénéficier d'un service.

Dans ce cas, pourquoi ne pas faire comme dans le domaine de l'éducation où tout est accessible maintenant? Si quelqu'un a besoin d'aide, on l'aide par le biais de la fiscalité ou par celui des bourses d'études.

Le système de santé n'a plus de limites et il faut en arriver à des solutions. Ces solutions devraient permettre à un individu de prendre des décisions quant à sa santé et lui permettre de bénéficier d'une aide financière s'il en a besoin.

Le système de santé devrait être davantage individualisé. On devrait essayer de trouver des formules permettant d'avoir accès aux services de santé un peu comme en éducation.

[Traduction]

M. Bliss: Je suis en accord avec tout ce que vous avez dit, sénateur. Oui, nous devons individualiser le régime. Le modèle de l'éducation est un modèle intéressant tout comme l'est celui d'autres pays qui ont à la fois un régime public et privé. Nous devons oublier notre obsession des États-Unis qui ont une série de problèmes particuliers. Il n'est pas nécessaire de suivre les Américains. Il y a d'autres possibilités. Je ne sais pas si la Scandinavie est toujours un modèle que nous devons suivre, ou si nous devrions plutôt nous tourner vers la Nouvelle-Zélande, l'Australie, la France ou l'Allemagne. Malheureusement, la Grande-Bretagne est plus pauvre que le Canada, et le régime à la fois public et privé qui existe là-bas ne semble pas très bien fonctionner.

M. Kent: Dans le cas des soins de santé, la plupart des gens ne prennent pas des décisions fondées sur les conditions du marché et n'ont jamais pris de telles décisions. Ils ne connaissent pas suffisamment ce qu'ils s'achètent. Ils s'en remettent au point de vue des médecins et des conseillants en soins de santé. S'ils devaient payer ces conseillers, ils n'iraient pas les voir s'ils n'avaient pas les moyens. S'ils ne sont pas obligés de payer, ils vont les voir.

La question n'est pas de savoir si moi-même ou Michael Bliss ou quiconque sommes en mesure de choisir nos soins de santé, de prendre nos propres décisions en matière de soins de santé. Les gens ont besoin d'avoir un régime de soins de santé. La question est de savoir si l'accès à ce régime, qu'on parle d'un régime de marché ou d'un régime public, est offert de façon organisée.

In the private health systems, nothing is more organized than the managed care systems in the United States. The issue, as I see it, is simply how the access to the system is determined. Obviously, the nature of the system is controlled, to a very considerable degree, by how one arrives at the access.

The idea that some set of planners or other group is going to make all the right decisions is nonsense. All the right decisions and detail can only be made by the medical profession, taking that in the broad sense: the medical professions. That is why it is so important that an efficient service be one that is delivered as a whole, whether it is hospital, doctor's office, home care, whatever, by the organized medical professions in a community.

Obviously, that can be done only within a clearly defined degree of public financing. That in turn certainly limits the range of the services that can be provided within the system. There are other separate services that some people may or may not be able to buy for themselves. Fine.

However, the basic system is either public or private. It is a system in any event, and if there is to be fair access to it then it is going to be public.

[Translation]

Senator Gill: I agree that we should continue to use specialists to get medical information of all types. Moreover, access to this ever-growing body of information has been greatly improved since medicare came into being.

Thirty or more years ago, we did not know about the beneficial or harmful effects of the food we ate. Now there is information on cans about the nutritional value of the ingredients they contain. In addition, I used to think that sugar was good, because it produced energy, but I know today that it can be harmful, because sugar is converted into fat.

[English]

Mr. Kent: Certainly, it is one of the positive developments. Much more is now known about the ways to be healthy. I see my 50-year-old sons running in marathons and things, which nobody at the age of 50 would have thought of doing in my day. They are a lot healthier than I was at that time.

The quality of the information is better. To the extent that the information has improved, then we are less dependent than we were on the advice of doctors, or whatever. However, that does not alter the fact that when it comes to what we do about our hearts or eyes or whatever, we need medical attention. The issue is the terms on which the public as a whole will have access to that medical attention, using again "medical" in the broad sense.

The Chairman: I am going to put three questions on the table, and you can both respond to them. Two of them are historical to assist us in understanding how we got to where we are.

Dans les régimes de santé publics, rien n'est plus organisé que les régimes de soins gérés aux États-Unis. À mon avis, la question est de savoir comment l'accès au régime est déterminé. De toute évidence, la nature du régime est contrôlée dans une très large mesure par la façon dont y a accès.

L'idée selon laquelle un groupe de planificateurs ou quiconque peut prendre toutes les bonnes décisions n'a aucun sens. Seule la profession médicale, au sens large du mot, c'est-à-dire les professionnels de la santé, sont à même de prendre les bonnes décisions. C'est pourquoi il est si important qu'un service efficace soit un service dont la prestation est assurée globalement, que ce soit à l'hôpital, au bureau du médecin, pour les soins à domicile, ou autres, par les professions médicales organisées au sein d'une collectivité.

Naturellement, cela n'est possible que grâce à un financement public clairement défini. Cela limite donc certainement la gamme de services qui peuvent être offerts dans le régime. Il y a d'autres services distincts que certaines personnes ont peut-être ou non les moyens de se payer. Très bien.

Cependant, le régime de base est soit public, soit privé. Quoi qu'il en soit, c'est un régime et pour que tous aient un accès équitable, ce doit être un régime public.

[Français]

Le sénateur Gill: Je suis d'accord pour que l'on continue de recourir aux spécialistes pour recevoir de l'information médicale de tout genre. D'ailleurs, l'accès à cette information toujours plus grande s'est grandement amélioré depuis la mise sur pied de l'assurance-santé.

Il y a 30 ans, et même plus, nous n'étions pas conscients des effets bénéfiques ou néfastes des aliments que nous consommions. Maintenant, sur les boîtes de conserve, par exemple, nous sommes renseignés sur la valeur nutritive des aliments qu'elles contiennent. Également, je croyais autrefois que le sucre était bon parce qu'il procurait de l'énergie mais aujourd'hui, je sais qu'il peut être néfaste car ce sucre est converti en graisse.

[Traduction]

M. Kent: Certainement, c'est là l'un des développements positifs. Nous en connaissons beaucoup plus aujourd'hui sur la façon de rester en bonne santé. Mes fils de 50 ans courent le marathon alors qu'à mon époque personne n'aurait songé à faire une telle chose à l'âge de 50 ans. Mes fils sont en bien meilleure santé que je l'étais moi à leur âge.

La qualité de l'information est meilleure. Dans la mesure où l'information s'est améliorée, nous dépendons moins des conseils des médecins ou d'autres. Cependant, cela ne change pas le fait que nous avons besoin de voir le médecin, que ce soit pour le coeur, les yeux ou autres. Il s'agit de savoir de quelle façon le public en général aura accès à ces services médicaux, et encore une fois j'utilise le terme «médical» au sens large du mot.

Le président: Je vais poser trois questions, et vous pouvez tous les deux y répondre. Deux des questions sont d'ordre historique pour nous aider à comprendre comment nous en sommes arrivés là.

As I listened to Professor Bliss describe some of the problems, it struck me that a huge piece of the problem was the decision made in the mid-1960s to move to fee for service rather than salary. It was fee for service that originally drove people to opt out. It was fee for service that then ultimately led to the Canada Health Act.

The first question would be whether you could enlighten us on why we ended up at fee for service, which it seems to me if we were starting out today is not the way we would go?

The second historical question, trying to understand the intent of the people who started medicare, has to do with what I would call the quality question. If one says that we would provide what the Canada Health Act would call all medically necessary services, there are a variety of different ways you could do that. For instance, a gall bladder operation can be done by cutting the body open or there can be a laparoscopy. Artificial hips can be aluminium or ceramic, which costs considerably more money. Mr. Kent was talking about cataract operations; well, they can be done with a laser or with the old-fashioned system.

Was the intent of the founders of medicare to provide medical service that would solve a problem, or was it to provide medical service at the leading edge of technology? In other words, there is a decision between making medical services free versus making the highest possible quality of medical services free.

My third question goes back to some comments Mr. Kent made. I, too, have been a very big fan of the notion of raising additional money for health care by effectively having the government issue a T4 slip based on the dollar value of medical services consumed by a family or by the individual taxpayer, provided, of course, it was capped so that you avoided the disaster scenario. That is a very progressive way of paying for it.

That raises money but does not deal with the fundamental problem, which is supply, that is to say, the availability of doctors. None of that is affected by effectively changing the tax system to make it a more equitable way, or a more progressive way, of raising funds for medical care.

I understand why Mr. Kent favours that system. I do also, but it is a taxing system, and does not fundamentally deal with the supply question. Would you comment on whether I am correct that that is simply a funding mechanism and does not deal with any of the other problems?

Mr. Kent, would you begin by responding to the first two questions, because you were involved in the fee for service decision, and the question of what relevant quality people thought they were providing at the time medicare was established?

En écoutant le professeur Bliss décrire certains des problèmes, ce qui m'a frappé c'est qu'une énorme partie du problème est attribuable à la décision prise vers le milieu des années 60 de passer à la rémunération à l'acte plutôt qu'au salaire. C'est la rémunération à l'acte qui a fait en sorte qu'initialement les gens ont décidé de ne pas participer. C'est la rémunération à l'acte qui en fin de compte a mené à la Loi canadienne sur la santé.

Ma première question est la suivante: pouvez-vous nous dire pourquoi nous nous sommes retrouvés avec la rémunération à l'acte, qui ne serait pas ce que nous choisirions aujourd'hui si nous pouvions tout recommencer?

Ma deuxième question d'ordre historique, pour essayer de comprendre ce que visaient ceux qui ont mis en place le régime d'assurance-maladie, concerne ce que j'appellerais la question de la qualité. Si l'on dit que nous devons offrir ce que la Loi canadienne sur la santé appelle des services nécessaires sur le plan médical, il y a toute une gamme de façons de le faire. Par exemple, une opération de la vésicule biliaire peut être effectuée selon la façon traditionnelle ou par laparoscopie. Les hanches artificielles peuvent être faites d'aluminium ou de céramique qui coûte beaucoup plus cher. M. Kent parlait de chirurgie de la cataracte; eh bien, cela peut se faire au laser ou de la façon traditionnelle.

L'intention des architectes de l'assurance-maladie était-elle d'offrir des services médicaux pour résoudre un problème ou des services médicaux à la fine pointe de la technologie? En d'autres termes, il faut décider si l'on veut offrir des services médicaux gratuits ou si l'on veut offrir gratuitement la meilleure qualité possible de services médicaux.

Ma troisième question revient à certaines observations qu'a faites M. Kent. Moi aussi j'ai été entièrement en faveur de l'idée de trouver des fonds supplémentaires pour le régime de soins de santé en faisant en sorte que le gouvernement puisse émettre un reçu T-4 calculé selon la valeur en dollars des services médicaux consommés par une famille ou par un contribuable pourvu, naturellement, qu'il y ait une limite de façon à éviter le désastre. Il s'agit là d'une façon très progressiste de financer le régime de soins de santé.

Cela permet de trouver des fonds, mais cela ne règle pas le problème fondamental qui est l'offre, c'est-à-dire la disponibilité des médecins. Le fait de changer le régime fiscal afin de permettre de financer le régime d'assurance-maladie d'une façon plus équitable, plus progressiste, ne change rien à ce problème.

Je comprends pourquoi M. Kent est en faveur de ce régime. Moi aussi je suis en faveur d'un tel régime, mais c'est un régime à assujettissement fiscal qui n'a fondamentalement rien à voir avec le problème de l'offre. Pouvez-vous me dire si à votre avis j'ai raison lorsque j'ai dit qu'il s'agit d'un simple mécanisme de financement et que cela n'a rien à voir avec les autres problèmes?

Monsieur Kent, pourriez-vous commencer par répondre aux deux premières questions, car vous avez participé à la décision relativement à la rémunération à l'acte, et à la question concernant la qualité des soins de santé à laquelle des architectes du régime de soins de santé songeaient lorsqu'ils ont créé le régime?

Mr. Kent: The position to accept fee for service was seen at the time, I think it is fair to say, as a matter of absolute necessity. A doctors' strike in Saskatchewan influenced this. There seemed to be no possibility of a smooth transition to publicly financed, tax financed health care unless it was on a fee for service basis.

The Chairman: I want to be sure that I understand. Was it an absolute necessity because it was the only practical way to solve the problem or because it was the best public policy?

Mr. Kent: Clearly, it was not the best public policy.

The Chairman: Did people understand that, even then?

Mr. Kent: Certainly. In fact, early on, before any decisions had been made, in about 1959 or 1960, I personally could not understand why priests, professors, and teachers could be paid by salary but it was somehow impossible to imagine that doctors should be paid by salary. Nonetheless, that was unquestionably the entrenched attitude of the profession, and to propose medicare on any other basis would, at the time, have been impossible. I think that many of us hoped that there would be some transition to a more salaried service. That has happened to some extent.

The Chairman: The current Ontario experiments are, in fact, designed to try to move more people in that direction.

Mr. Kent: That is correct, and I think it will continue. I wrote a memorandum about that, a short while ago, urging that that was the way to move away from fee for service and, in time, towards a more salaried service. I do not think there was any question that it was the right decision at the time. This has occurred, not primarily because of the sins of the planners, but because of the reluctance of politicians to come to grips with problems before they need to. We have been much slower than we might have been to make the gradual transition from fee for service to a more civilized system.

In respect of the quality issue, I have to say that I do not think the issue was faced as sharply by any of us as, in retrospect, it might have been. It must be remembered that nobody, at that stage, anticipated the decline in fertility of the Canadian people. That is the real point about the aging population. It is not primarily that people are living longer, though they are to some extent; rather, it is, above all, that fewer people are being born. That has thrown out many of the calculations of what lay in the future, in a way that I do not think either the market system or the public system clearly anticipated in time.

The assumption was that, if public health insurance was established, then that would, indeed, encourage, rather than discourage, progress in the development of better health care, and that it would remain true, as the whole intent of the system was,

M. Kent: Je crois que l'on peut dire qu'à l'époque, la question de la rémunération à l'acte était considérée comme une nécessité absolue. Une grève des médecins au Saskatchewan a influencé cette décision. Il semblait impossible d'assurer une transition sans heurt à un régime financé à même les fonds publics, un régime de soins de santé financé par les impôts, à moins d'avoir la rémunération à l'acte.

Le président: Je veux être sûr de bien comprendre. Était-ce une nécessité absolue parce que c'était la seule façon pratique de résoudre le problème ou parce que c'était la meilleure politique gouvernementale possible?

M. Kent: Il est clair que ce n'était pas la meilleure politique gouvernementale.

Le président: Est-ce que les gens comprenaient cela, même à l'époque?

M. Kent: Certainement. En fait, dès le début, avant que les décisions ne soient prises, en 1959 ou 1960, personnellement, je ne pouvais comprendre pourquoi les prêtres, les professeurs et les enseignants pouvaient être rémunérés en recevant un salaire, mais qu'il était en quelque sorte impossible d'imaginer que les médecins puissent recevoir un salaire. Quoi qu'il en soit, il ne fait aucun doute que cette attitude était bien ancrée dans la profession, et il aurait été impossible de proposer un régime d'assurance-maladie qui aurait été fondé sur un autre type de rémunération. Je pense que bon nombre d'entre nous espéraient qu'il y aurait une transition vers un régime davantage axé sur les salaires. C'est ce qui est arrivé dans une certaine mesure.

Le président: Les mécanismes qu'on veut implanter aujourd'hui en Ontario visent effectivement à favoriser un tel mouvement.

M. Kent: C'est exact et je pense que la tendance va se maintenir. J'ai rédigé il n'y a pas longtemps une note pour dire que c'était ainsi qu'il fallait procéder pour s'écarter de la rémunération à l'acte et en arriver graduellement à des services davantage axés sur des salaires. Je suis convaincu que c'était la bonne décision à l'époque. Le problème actuel ne vient pas tellement d'une erreur de conception de la part des planificateurs, mais plutôt du fait que les décideurs politiques n'ont pas voulu s'attaquer aux problèmes avant qu'ils n'y soient forcés. La transition de la rémunération à l'acte à un régime plus civilisé s'est fait beaucoup plus lentement qu'elle aurait pu se faire.

Relativement à la qualité, je dois dire qu'aucun d'entre nous ne s'est penché d'aussi près que nous aurions pu le faire sur cette question. Il ne faut cependant pas oublier que personne ne prévoyait à l'époque une telle baisse du taux de natalité des Canadiens. C'est l'aspect le plus important d'une population vieillissante. Cela ne vient pas surtout du fait que les gens vivent plus vieux, même si c'est vrai dans une certaine mesure, mais plutôt du fait qu'il y a moins de naissances qu'auparavant. C'est ce qui a faussé une bonne partie des calculs et ni le système du marché ni le système public ne l'avaient prévu à l'époque.

On supposait à l'époque que, si l'on créait un régime d'assurance-santé public, cela favoriserait l'établissement de meilleurs soins de santé plutôt que le contraire et que cela continuerait vu que l'on voulait avant tout que les meilleurs

that, as the quality of health care improved, the extra quality and the more sophisticated techniques, and so on, should be available primarily on the basis of need. If somebody had a poor heart, so to speak, early in life, then it was terribly important that the best possible operation be performed for that person early in life. It was perhaps less important that those sophisticated techniques be used in the cases where the chances of long-term recovery were less good. There was obviously no anticipation that the very best of health care could always be provided in every case of every possible need.

The Chairman: Would you agree that that is the current public expectation?

Mr. Kent: No. We can, perhaps all too easily, say what the public attitude is because, obviously, every individual would like the best for himself. However, I do not think there is a public expectation as a matter of policy that the very best should be provided irrespective of the degree of need in every case. It is likely that most of us magnify our own needs as opposed to other people's.

Regarding the T4 slip issue, I still think that that is of fundamental importance, not because it would, as you say, contribute greatly to the supply problem. However, we should remember that doctors, perhaps more than most of us, are aware of the significance of income tax. If their patients were having to contribute, through the tax system, directly to a significant extent to what the doctor recommended for them, then the tendency to misuse the fee for service system for unnecessary services would be somewhat weakened on the supply side, as well as on the demand side.

The Chairman: I want to press you on your question of need. Forget whether opinion polls would show that average Canadians think that they should be entitled to the best quality of care — they certainly think that they, as individuals, should be entitled to the best quality of health care, although they are not sure that everyone else should be — and deal with the concept of need. I am puzzled about that concept of need. Here is my problem: Do you attempt to take the same route, for example, as the State of Oregon? I am just picking them as an example because they have attempted to define need, whereby, for instance, for people past a certain age, and it is somewhere in the eighties, a hip replacement will not be done? Their view is akin to what you were saying: if someone needed a heart operation in their 30s, that was of greater need than someone who happened to be substantially older. Are you saying that the people who developed the original policy for medicare had at least reflected on the notion that there might be this allocation of services based on need? I ask that because my sense is that that is about the most politically impossible thing to do explicitly. Now, we may well do it implicitly. We do it implicitly by rationing systems; we do it implicitly in all kinds of ways. There are public rules respecting speed limits and there are other things that are designed to minimize the number of accidents but not eliminate them. Therefore, we have implicitly, whether we like it or not, put a cost on the value of human life and the value of human injury. It is one thing to do it implicitly, where you cannot identify the decision-maker and the particular

services et les techniques plus modernes de soins de santé soient disponibles surtout en fonction des besoins. Si quelqu'un avait un problème cardiaque pendant son jeune âge, il était très important de lui offrir la meilleure chirurgie possible au début de sa vie. C'était peut-être moins important d'utiliser ces techniques perfectionnées dans les cas où les perspectives de rétablissement à long terme étaient moins évidentes. On ne pensait certes pas que les meilleurs soins de santé possible pourraient toujours être fournis dans tous les cas et quels que soient les besoins.

Le président: Pensez-vous que c'est ce que veut maintenant le public?

M. Kent: Non. Bien sûr, on peut toujours dire quelle est l'attitude du public parce que chacun voudrait les meilleurs services possible pour soi-même. Cependant, je ne pense pas que le public juge qu'on doive systématiquement fournir par principe les meilleurs services possible quels que soient les besoins dans tous les cas. La plupart d'entre nous ont cependant tendance à exagérer nos propres besoins par rapport à ceux des autres.

Relativement au T-4, je pense encore que c'est d'une importance fondamentale, mais pas parce que cela aiderait beaucoup à régler le problème de l'offre, comme vous l'avez dit. Il faut cependant tenir compte du fait que, peut-être plus que la plupart d'entre nous, les médecins se rendent compte de l'importance de l'impôt sur le revenu. Si les patients devaient financer directement grâce à l'impôt les services que leurs médecins recommandent, les gens auraient moins tendance à abuser de la rémunération à l'acte en réclamant ou en offrant des services inutiles.

Le président: Je voudrais que vous élaboriez à propos des besoins. Peu importe si les sondages d'opinions montrent que le Canadien moyen juge avoir droit aux soins de la meilleure qualité possible, vu qu'il considère certainement qu'il a le droit à la meilleure qualité possible de soins de santé, même s'il n'est pas nécessairement convaincu que tous doivent y avoir droit, et parlons un peu de la notion du besoin. Cela me laisse un peu perplexe. Devrions-nous, par exemple, suivre l'exemple de l'Oregon? Je prends cet exemple au hasard parce que cet État a essayé de définir les besoins de façon à dire que, passé un certain âge, quelque part après 80 ans, on ne pratiquerait plus d'arthroplastie de la hanche. Le raisonnement est un peu semblable au vôtre: si quelqu'un a besoin de chirurgie cardiaque pendant la trentaine, le besoin est jugé comme plus grand que si le malade est plus âgé. Voulez-vous dire que les auteurs du régime de soins de santé au départ avaient au moins réfléchi à la possibilité que les services soient dispensés selon les besoins? Je pose la question parce que je trouve qu'un tel système serait le moins possible à appliquer de façon explicite sur le plan politique. Nous pourrions bien le faire de façon implicite. Nous le faisons implicitement si nous avons des systèmes de rationnement et nous pouvons le faire implicitement de toutes sortes de façons. Le code de la route fixe des limites de vitesse et prévoit d'autres mesures pour réduire au minimum le nombre d'accidents, mais ne parvient pas à les éliminer. Que nous soyons d'accord ou non, nous avons donc implicitement attribué un coût à la vie humaine et aux

consequences. It is another to do it explicitly in the way that I heard you suggesting. Am I right or wrong?

Mr. Kent: There is no question that the driving concept of the time was that financial consideration should be removed from the assessment of need. It should be unrelated to finances. That was the politically driving motivation and, I hope, the surviving one.

There was, at the decision-making level at that time, the assumption that it was to take place in an environment where the quality of medical services was to improve. The federal government, before medicare was introduced and before hospital insurance was introduced, put a lot of money into medical education, hospitals and medical research. Therefore the assumption was that there would be improvements in the level of service, but I do not think that there was a failure to know in one's heart, or one's mind, that various kinds of rationing are inevitable. Nothing can be done without rationing. You cannot hold a committee meeting without rationing time, and so on and so forth. Any system, public or private, is going to use a degree of rationing. There is no question about that. Obviously, for the reasons that you have given, no politician is going to say a great deal about that in very explicit terms. There is no reason why he should, because the decisions, in detail, are going to be made within the system, when it is set up, essentially by the doctors. In other words, it is a system in which doctors make those decisions according to a reasonable assessment of comparative need and not according to funds.

Mr. Bliss: I agree with that. Medicine has moved so far and so fast in 30 years that these issues were not being discussed at that time. Hip operations were not available; they could not be done. There was a sense in the 1960s that we could meet our health care needs. However, we have found that that is not the case.

Yes, rationing will be a problem. My answer to a rationing dilemma is: Let us do everything we can to avoid it by pouring more and more resources into health care, both public and private, because I think that is a good cause. It is better to do that than to spend them on BMWs. Let the state provide more hip replacements and if the state is near the limit of its resources, it can reduce the queues by letting private people do hip replacements.

I do not understand the complexities of the tax system. I think that the tax issue also shades into the medical savings account issue and the voucher issue. That is what we hire experts to tell us about.

Regarding fee for service, I am a salaried professor at the University of Toronto. However, if one of my students called me up at three o'clock in the morning for advice on his exam, I would tell him to go away.

Senator Carstairs: So would the doctor.

blessures que peut subir l'être humain. C'est une chose de le faire implicitement lorsqu'on ne peut pas dire qui a décidé et dans quelles circonstances le système va s'appliquer, mais c'est une autre chose de le faire explicitement comme vous semblez le proposer. Ai-je raison ou non?

M. Kent: La principale motivation à l'époque, c'était qu'on devait faire abstraction des considérations financières pour évaluer les besoins. Il ne devait pas y avoir de rapport entre les besoins et les moyens financiers du patient. C'était la principale motivation politique à l'époque et j'espère que c'est celle qui a survécu.

À ce moment-là, les décideurs considéraient que la qualité des services médicaux continuerait de s'améliorer. Avant l'instauration de l'assurance-maladie et de l'assurance-hospitalisation, le gouvernement fédéral avait investi beaucoup dans la formation de médecins, les hôpitaux et la recherche médicale. On supposait donc que le niveau des services s'améliorerait mais je ne pense pas qu'on ignorait dans le fond qu'un rationnement quelconque était inévitable. On ne peut rien faire sans rationnement. On ne peut pas tenir de réunion de comité sans rationner son temps, et c'est la même chose pour tout le reste. N'importe quel régime, qu'il soit public ou privé, rationnera les services dans une certaine mesure. C'est inévitable. Bien sûr, pour les raisons que vous avez évoquées, personne ne va en dire grand-chose de façon très explicite au niveau politique. Ce n'est d'ailleurs pas nécessaire d'en parler parce que ce sont essentiellement les médecins qui vont prendre ces décisions à l'intérieur du régime lui-même. Autrement dit, le régime fait en sorte que les médecins prennent les décisions après avoir fait une évaluation raisonnable des besoins comparatifs et non pas des moyens financiers.

M. Bliss: Je suis bien d'accord. On a accompli tellement de progrès depuis 30 ans en médecine qu'on ne parlait pas de tout cela à l'époque. L'arthroplastie de la hanche n'existait pas. Dans les années 60, nous pensions pouvoir satisfaire à tous nos besoins de soins de santé, mais nous avons constaté que ce n'est pas le cas.

Le rationnement sera effectivement un problème. La solution que je propose est celle-ci: Efforçons-nous d'éviter le problème de rationnement en investissant de plus en plus de ressources dans les soins de santé publics et privés. C'est une dépense utile. C'est mieux que dépenser pour des BMW. Que l'État finance plus d'arthroplasties de la hanche et, si les ressources de l'État sont trop restreintes, on pourra réduire les files d'attente en laissant les cliniques privées faire ces chirurgies.

Je ne comprends pas les complexités du régime fiscal. Pour moi, cette discussion nous rapproche des comptes d'épargne médicale et des bons. C'est pour cela que nous embauchons des experts.

Pour ce qui est de la rémunération à l'acte, je suis moi-même professeur salarié de l'Université de Toronto. Si l'un de mes étudiants m'appelait à trois heures du matin pour me demander conseil au sujet d'un examen, je lui dirais de retourner se coucher.

Le sénateur Carstairs: Le médecin aussi.

Mr. Bliss: Similarly, if the university said to me, "You cannot take a fee for anything you write in *The Globe and Mail*," maybe I would say, "Well, I will leave," or "I want a higher salary, if I have to give my fees to the university."

The Chairman: Or perhaps "I will not write for *The Globe and Mail*."

Mr. Bliss: There is being on salary and being on salary. It seems to me that the idea of abolishing fee-for-service medicine is another panacea, another sort of planner's way out. One would be saying that the system is not working, so we must bring these doctors under the tight control that putting them on salary involves. Mr. Kent said that it was desirable public policy, but it was not practical back then. It strikes me that impractical public policy is never desirable. You could not do it; but say you had done it; it is hard to get one's mind around the idea that, if we had our whole medical profession on salary these days, as salaried civil servants, we would have a better, more effective, more efficient health care system. I just find that inherently implausible.

I think there are good reasons for fee-for-service medicine. In truth, in North America we have a long history of contract medicine in which doctors did agree to service rosters of patients in contract with a lumber company to be their doctor for a dollar a head. That never seemed to work terribly well. One of the reasons is that the patients, of course, will, if anything, up their demands on the physicians. The physicians have no incentive to respond to the demands and there is a clash between the provider and the client.

Technically, it was also unpopular in Canada in the 1950s, because rostering in the U.K. under the national health system seemed very unpopular, at least in the eyes of North American doctors. I think that the idea of experimenting, of paying a doctor a high enough salary — yes, he or she will abandon fee for service. You can do it, but you may find, in fact, that it is certainly not going to help your costs at all.

It may be part of a pluralist application, but the idea that you could ever go over entirely to abolishing fee for service strikes me as utterly utopian.

The Chairman: I thank the two of you for what has been an absolutely fascinating history lesson. We really appreciate your taking the time to do so. This has been wonderful.

I say to my colleagues, particularly in light of the comments that the two witnesses have made this morning, that our session next Wednesday will feature three people who have recently completed a not yet published study of the comparative medical systems in Western Europe and Australia and New Zealand, and how they compare and differ from the Canadian system. That will be our session next Wednesday.

The committee adjourned.

M. Bliss: Par ailleurs, si l'université me disait que je ne peux pas accepter de me faire payer pour un article que j'ai rédigé pour le *Globe and Mail*, je répondrais sans doute que dans ce cas, je démissionne, ou bien que je veux être mieux payé si je dois remettre mes honoraires à l'université.

Le président: Ou peut-être que je refuserai d'écrire pour le *Globe and Mail*.

M. Bliss: Êtes salarié peut vouloir dire bien des choses. Il me semble que la notion selon laquelle on peut abolir la rémunération à l'acte dans les services médicaux payants est une autre idée utopique, une autre solution de planificateur. Cela reviendrait à dire que le système ne fonctionne pas et qu'il faut exercer un contrôle plus strict sur les médecins en leur versant un salaire. M. Kent a dit que c'était souhaitable à l'époque sur le plan de la politique publique, mais que c'était impossible à réaliser. Il me semble quant à moi qu'une politique publique impossible à réaliser n'est jamais souhaitable. On n'aurait pas pu le faire, mais supposons qu'on l'ait fait; je vois mal comment nous pourrions avoir un régime de soins de santé plus efficace, plus économique, si tous nos professionnels de la santé étaient rémunérés aujourd'hui comme des fonctionnaires. Ce n'est tout simplement pas plausible.

À mon avis, il y a de bonnes raisons à avoir la rémunération à l'acte dans les services médicaux. En Amérique du Nord, il y a longtemps eu des services médicaux à contrat selon lesquels les médecins acceptaient de traiter tous les employés d'une compagnie forestière, par exemple, pour un dollar chacun. Le système n'a jamais très bien fonctionné. Cela vient, bien sûr, du fait que les patients demandent plus de services des médecins et que ceux-ci ne sont pas incités à répondre à la demande. Il y donc conflit entre le fournisseur de services et le client.

Cette notion n'était pas très bien vue au Canada dans les années 50. Les médecins nord-américains voyaient d'un très mauvais oeil l'attribution de listes de malades aux médecins comme on le faisait au Royaume-Uni dans le cadre du régime national de santé. Selon moi, on pourrait toujours convaincre les médecins de renoncer à la rémunération à l'acte si leurs salaires étaient assez élevés. On pourrait toujours le faire, mais on risque de constater que cela ne réduira pas les coûts.

On pourrait peut-être y avoir recours dans le cadre d'un système pluraliste, mais la notion qu'on puisse un jour abolir entièrement la rémunération à l'acte me semble tout à fait utopique.

Le président: Je vous remercie tous deux d'une leçon d'histoire tout à fait fascinante. Nous vous sommes très reconnaissants d'avoir pris le temps de nous parler. Votre participation a été vraiment merveilleuse.

Je signale à mes collègues, vu surtout ce que nos deux témoins nous ont dit ce matin, que nous entendrons à la prochaine séance mercredi trois personnes qui ont récemment terminé une étude comparative des régimes médicaux d'Europe occidentale, d'Australie et de Nouvelle-Zélande, axée sur le régime canadien, mais qui n'ont pas encore publié les résultats de l'étude. Nous entendrons ces témoins mercredi prochain.

La séance est levée.



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WITNESSES—TÉMOINS

Wednesday, May 3, 2000:

From Health Canada:

Cliff Halliwell, Director General, Applied Research and
Analysis Directorate, Information, Analysis and
Connectivity Branch;

Abby Hoffman, Senior Policy Advisor;

Frank Fedyk, Acting Director, Canada Health Act Division,
Intergovernmental Affairs Directorate, Policy and
Consultation Branch.

Thursday, May 4, 2000:

As an individual:

Tom Kent.

From the University of Toronto:

Michael Bliss, President.

Le mercredi 3 mai 2000:

De Santé Canada:

Cliff Halliwell, directeur-général, Direction de la recherche
appliquée et de l'analyse, Direction générale de
l'information, de l'analyse et de la connectivité;

Abby Hoffman, conseillère principale en politique;

Frank Fedyk, directeur intérimaire de la division de la Loi
Canadienne sur la santé, Direction des affaires
intergouvernementales, Direction générale des politiques et
de la consultation.

Le jeudi 4 mai 2000:

À titre individuel:

Tom Kent.

De l'Université de Toronto:

Michael Bliss, président.

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Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

*Proceedings of the Standing
Senate Committee on*

*Délibérations du comité
sénatorial permanent des*

Social Affairs, Science and Technology

Affaires sociales, des sciences et de la technologie

Chairman:
The Honourable MICHAEL KIRBY

Président:
L'honorable MICHAEL KIRBY

Wednesday, May 10, 2000
Thursday, May 11, 2000

Le mercredi 10 mai 2000
Le jeudi 11 mai 2000

Issue No. 14

Fascicule n° 14

Eighth and ninth meetings on:
The state of the health care system in Canada

Huitième et neuvième réunions concernant:
L'état du système de santé au Canada

WITNESSES:
(See back cover)

TÉMOINS:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Cook
Beaudoin	Fairbairn, P.C.
* Boudreau, P.C.	Gill
(or Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Robertson

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee:

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Banks substituted for that of the Honourable Senator Pépin (*May 10, 2000*).

The name of the Honourable Senator Gill substituted for that of the Honourable Senator Corbin (*May 10, 2000*).

The name of the Honourable Senator Beaudoin substituted for that of the Honourable Senator Meighen (*May 8, 2000*).

The name of the Honourable Senator LeBreton substituted for that of the Honourable Senator Atkins (*May 8, 2000*).

The name of the Honourable Senator Pépin substituted for that of the Honourable Senator Milne (*May 8, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES AFFAIRES SOCIALES, DES SCIENCES ET DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjory LeBreton

et

Les honorables sénateurs:

Banks	Fairbairn, c.p.
Beaudoin	Gill
* Boudreau, c.p.	Keon
(ou Hays)	* Lynch-Staunton
Callbeck	(ou Kinsella)
Carstairs	Robertson
Cohen	
Cook	

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Banks substitué à celui de l'honorable sénateur Pépin (*le 10 mai 2000*).

Le nom de l'honorable sénateur Gill substitué à celui de l'honorable sénateur Corbin (*le 10 mai 2000*).

Le nom de l'honorable sénateur Beaudoin substitué à celui de l'honorable sénateur Meighen (*le 8 mai 2000*).

Le nom de l'honorable sénateur LeBreton substitué à celui de l'honorable sénateur Atkins (*le 8 mai 2000*).

Le nom de l'honorable sénateur Pépin substitué à celui de l'honorable sénateur Milne (*le 8 mai 2000*).

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, May 10, 2000

(20)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 3:52 p.m., the Chairman, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Banks, Carstairs, Cohen, Fairbairn, P.C., Gill and Kirby (6).

Also in attendance: The official reporters of the Senate.

WITNESSES:

From the University of Western Ontario:

Ake Blomqvist, Professor.

From the University of Toronto:

Colleen Flood, Professor;

Mark Stabile, Professor.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see proceedings of the committee, Issue No. 8.*)

The Chairman made a statement.

Professor Blomqvist made a statement. Professor Stabile made a statement. Professor Flood made a statement. The witnesses answered questions.

At 5:30 p.m., the committee adjourned to the call of the Chair.

ATTEST:

OTTAWA, Thursday, May 11, 2000

(21)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 11:10 a.m., the Chairman, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Callbeck, Carstairs, Cohen, Fairbairn, P.C., Gill, Kirby and Keon (7).

Also in attendance: The official reporters of the Senate.

WITNESSES:

From the Canadian Institute for Health Information:

John S. Millar, Vice-President, Research and Analysis.

PROCÈS-VERBAUX

OTTAWA, le mercredi 10 mai 2000

(20)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 15 h 52, dans la salle 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Banks, Carstairs, Cohen, Fairbairn, c.p., Gill et Kirby (6).

Aussi présents: Les sténographes officiels du Sénat.

TÉMOINS:

De l'Université Western Ontario:

Ake Blomqvist, professeur.

De l'Université de Toronto:

Colleen Flood, professeure;

Mark Stabile, professeur.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale de l'état du système de santé au Canada. (*Le texte intégral de l'ordre de renvoi figure dans les délibérations du comité, fascicule n° 8.*)

Le président fait une déclaration.

M. Blomqvist fait un exposé. M. Stabile fait un exposé. Mme Flood fait un exposé. Les témoins répondent aux questions.

À 17 h 30, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

OTTAWA, le jeudi 11 mai 2000

(21)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 11 h 10, dans la salle 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Callbeck, Carstairs, Cohen, Fairbairn, c.p., Gill, Kirby et Keon (7).

Aussi présents: Les sténographes officiels du Sénat.

TÉMOINS:

De l'Institut canadien d'information sur la santé:

John S. Millar, vice-président, Recherche et analyse.

From McGill University:

Margaret Somerville, Professor.

From the University of Alberta:

Laura Shanner, Professor.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see proceedings of the committee, Issue No. 8.*)

The Chairman made a statement.

Dr. Millar made a statement and answered questions.

The Chairman made a statement.

Professor Somerville made a statement. Professor Shanner made a statement. The witnesses answered questions.

At 1:20 p.m., the committee adjourned to the call of the Chair.

ATTEST:

De l'Université McGill:

Margaret Somerville, professeure.

De l'Université de l'Alberta:

Laura Shanner, professeure.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale de l'état du système de santé au Canada. (*Le texte intégral de l'ordre de renvoi figure dans les Délibérations du comité, fascicule n° 8.*)

Le président fait une déclaration.

M. Millar fait un exposé et répond aux questions.

Le président fait une déclaration.

Mme Somerville fait un exposé. Mme Shanner fait un exposé. Les témoins répondent aux questions.

À 13 h 20, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

EVIDENCE

OTTAWA, Wednesday, May 10, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 3:52 p.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Honourable senators, we are here to continue our study on the health system in Canada, to determine what needs to be done to improve it and to understand the federal role in health policy and the health care system.

Our witnesses today will deal with comparisons between the Canadian system and systems in other countries. You will recall, from our outline, that the first phase of the study is an overview of all of the major issues. Starting in the fall, we will do an in-depth study of several of the issues, including a comparison between Canada and other health care systems and what Canada can learn from them. Our purpose today is not to do an exhaustive study of a comparative nature but rather to understand, at the overview level, some of the similarities and differences.

Our witnesses today are three members of the academic community, Ake Blomqvist, from the University of Western Ontario, and Mark Stabile and Colleen Flood from the University of Toronto. They have just completed a study that looked at international comparisons, in part for the Ontario Medical Association, I believe, who have been one of the sponsors. Their purpose today is to give us an overview of comparisons. As I said, we will be looking at this issue in much greater depth down the road.

Professor Blomqvist will talk about a paper called "Health Care System: Some International Comparisons," in which he is looking at European comparisons.

Mr. Ake Blomqvist, Professor of Health Economics, University of Western Ontario: As a person with a longstanding interest in comparative health policy, I certainly appreciate the opportunity to appear before the committee. I will look at the health care system in a couple of the selected countries that appear in the table, which is from the material that may have been distributed to you. I have chosen the United Kingdom and the Netherlands because I think their health services systems differ from the Canadian one, particularly in important institutional respects.

You will also see from the overhead that one very important way in which these systems differ from the Canadian one is in terms of cost. I will say a few words about one part of the American system, which, as you may know, is the most expensive health care system in the world. Their per capita spending is close to U.S. \$4,000 as compared to Canadian spending of around U.S. \$2,000 per capita, with corresponding differences in terms of the share of GDP that is devoted to health services. The other countries, of course, are also interesting in the sense that they do

TÉMOIGNAGES

OTTAWA, le mercredi 10 mai 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 15 h 52 pour examiner l'état du système de santé au Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Honorables sénateurs, nous poursuivons aujourd'hui notre étude du système de santé au Canada. Nous voulons établir ce qu'il convient de faire pour l'améliorer et nous voulons aussi comprendre quel rôle le gouvernement fédéral doit jouer dans l'élaboration de la politique en matière de santé et dans la mise en oeuvre du système de santé.

Nos témoins d'aujourd'hui compareront le système canadien aux systèmes d'autres pays. La première phase de notre étude vise à nous permettre de faire ressortir les grandes questions qui se posent dans le domaine de la santé. À compter de l'automne, nous étudierons à fond plusieurs de ces questions et nous comparerons notamment le système de santé du Canada à celui d'autres pays. Les témoins que nous entendrons aujourd'hui nous donneront un bref aperçu des similitudes et des différences entre les divers systèmes de santé.

Nous accueillons aujourd'hui des universitaires. Il s'agit de M. Ake Blomqvist, de l'université Western Ontario, de M. Mark Stabile et de Mme Colleen Flood de l'Université de Toronto. Nos trois témoins viennent de terminer une étude faisant une comparaison internationale des systèmes de santé en partie pour le compte de la Ontario Medical Association. Leur objectif aujourd'hui est de nous donner un aperçu des différents systèmes de santé. Comme je l'ai dit, nous étudierons plus à fond cette question un peu plus tard.

M. Blomqvist nous entretiendra d'un document intitulé «Health Care System: Some International Comparisons», dans lequel il compare notre système au système européen.

M. Ake Blomqvist, professeur d'économie de la santé, université Western Ontario: Étant donné que je m'intéresse depuis longtemps à l'étude comparative des politiques de santé, j'apprécie grandement l'occasion qui m'est donnée de comparaître devant le comité. Je vais vous entretenir des systèmes de santé de certains pays choisis qui figurent dans le tableau que vous trouverez dans le document qui vous a été distribué. J'ai choisi de comparer notre système à ceux du Royaume-Uni et des Pays-Bas parce que je pense que les systèmes de santé de ces pays diffèrent du système canadien, en particulier en ce qui a trait à divers importants aspects institutionnels.

Cette diapositive vous montre également que les dépenses engagées au titre de la santé diffèrent dans les trois pays que je compare. Permettez-moi de vous dire quelques mots au sujet du système de santé américain qui, comme vous le savez, est le plus coûteux au monde. Les dépenses par habitant au titre de la santé aux États-Unis s'élèvent à 4 000 \$ contre 2 000 \$ au Canada. L'écart dans la proportion du PIB qui est consacrée aux services de santé dans nos deux pays est analogue. Le cas des autres pays sur lesquels porte cette étude est également intéressant parce qu'il

show the possibility of running a modern and, apparently, fairly serviceable health services system with far fewer resources than Canada uses. In terms of percentage of GDP, the United Kingdom spends less than 7 per cent of GDP on health services as opposed to more than 9 per cent in Canada and as much as 14 per cent in the United States, which is the most recent figure.

One set of numbers that I have not shown in this table has to do with the significance of health care for the elderly in these various countries. The percentage of total health services spending that is accounted for by spending for individuals over age 65 in these countries is in the neighbourhood of 40 per cent. Thus, given that the proportion of people over 65 is a much smaller proportion of the total population, that translates into spending for people over 65 in an amount, on average, of four times as large per capita as spending on people under 65. Given the coming demographic changes in Canada, this is an issue that in the long term will be of concern.

When I teach my comparative health system classes, I typically start with a diagram of the type that I have just put on the board. I stress the difference between the health services system and an ordinary market, in which buyers, who in the health services system would be patients, simply buy the services of sellers, who are the providers — in other words, the doctors and hospitals that supply health services. In ordinary markets, the providers supply the services, and in this case the buyers pay the money directly to the providers. This is the sort of supply/demand model that economists study. The way in which the health services system is different institutionally, in a major way from a regular market, has to do with the existence of a third party that does the funding — in other words, the insurer, who, of course, may be either public or private. Therefore, most of the payments for services provided by doctors and hospitals in health services systems do not come directly from patients. Instead, they come from either the private insurer in the system or from the government, in systems with public insurance such as the Canadian system. In turn, the payments from the buyers come in the form of insurance premiums or taxes, from the patients or users to the funding agency, which may be the government or private insurers.

Given this unusual organizational set-up, in comparison with the standard economic market, much of what is distinctive about the analysis of the health services industry, or the health care system, has to do with institutional arrangements that involve the third-party funding agency. On the one hand, there are institutional arrangements between the insuring agency — the insurance plan — and the patients on the other hand.

Are there user charges? What does the insurance plan, whether it is explicit or implicit, specify about what is included in the coverage? What is not included? All of these questions relate to this link between the patients and the third-party agency that does the funding. An important question, of course, for patients is whether they have any choice among insurance plans. In a system such as the Canadian one, there is no choice. In many other

fait ressortir le fait qu'il est possible de mettre en oeuvre un système de santé moderne qui répond apparemment aux besoins de la population avec des ressources beaucoup plus limitées que celles dont dispose le Canada. À titre d'exemple, le Royaume-Uni consacre moins de 7 p. 100 de son PIB aux services de santé alors que le Canada en consacre 9 p. 100 et les États-Unis, 14 p. 100, selon les statistiques les plus récentes.

Ce tableau ne comporte pas de données sur la consommation des services de santé par les personnes âgées dans ces divers pays. Le pourcentage des dépenses de santé engagées pour répondre aux besoins des personnes de plus de 65 ans dans ces pays représente 40 p. 100. Compte tenu du fait que cette couche de population est beaucoup moins importante que la population totale, cela signifie que les dépenses par habitant pour les personnes de plus de 65 ans sont quatre fois supérieures à ce qu'elles sont pour les personnes de moins de 65 ans. Compte tenu des changements démographiques qui s'annoncent au Canada, cette question revêtira beaucoup d'importance à long terme.

Quand je donne mes cours sur les divers régimes de soins de santé, je commence d'habitude par un diagramme comme celui que je viens de mettre au tableau. Je souligne la différence entre un régime de services de santé et un marché ordinaire où les acheteurs, c'est-à-dire les patients dans un régime de soins de santé, achètent simplement les services de vendeurs, autrement dit les fournisseurs B, les médecins et les hôpitaux qui offrent les soins de santé. Dans un marché ordinaire, les fournisseurs offrent le service et les acheteurs paient directement les fournisseurs. C'est le genre de modèle d'offre et de demande que connaissent les économistes. Les régimes de soins de santé sont très différents d'un marché ordinaire sur le plan institutionnel à cause de l'existence d'un tiers qui finance le fournisseur B, autrement dit, l'assureur, qui peut être soit public soit privé. La plus grande partie des paiements pour les services fournis par les médecins et les hôpitaux dans un régime de soins de santé ne vient donc pas directement des patients. Les paiements sont versés soit par l'assureur privé, soit par le gouvernement lorsqu'il s'agit d'un régime d'assurance publique, comme au Canada. De leur côté, les acheteurs effectuent des paiements sous forme de primes d'assurance ou d'impôt que versent les patients ou utilisateurs à l'agence de financement, qui peut être soit le gouvernement, soit l'assureur du secteur privé.

Vu cette structure inusitée par rapport au marché économique ordinaire, lorsqu'on fait l'analyse de l'industrie des services de santé ou du régime de soins de santé, la principale différence concerne les arrangements institutionnels de l'agence de financement. Il y a donc les arrangements institutionnels entre l'assureur, c'est-à-dire le régime d'assurance d'une part, et les patients de l'autre.

Y a-t-il des frais à payer par l'utilisateur? Quels services sont assurés explicitement ou implicitement par le régime d'assurance? Quels services ne sont pas inclus? Ce sont toutes des questions qui touchent les liens entre les patients et l'agence de financement. Bien entendu, une question importante pour les patients consiste à savoir s'ils peuvent choisir leurs régimes d'assurance. Dans un régime comme le régime canadien, ils n'ont pas le choix. Ailleurs,

systems, including the British system, there is some degree of choice even though it is largely a public system.

The other link where institutional arrangements become exceptionally important is the relationship between the third-party funding agency, the government, or the insurance plans, on the one hand, and the providers who provide the services to the insured clients on the other hand. Here, you get into issues such as the rates that providers are paid, the determination of these rates — whether through competition or through negotiated regulated prices — and the inclusion of managed care, as there is now on the increase in the United States. In other words, are there rules imposed by the insurers to control the way in which the providers provide the services that the users benefit from?

A very important issue has to do with the link between primary care providers — the family doctors or general practitioners that represent the first line of defence of the health services system or the first point of contact between patients and the health services system and the arrangements between those primary care providers — and those who provide what is by far the most expensive portion of the total health services budget, namely hospital services and the services of specialists. In other words, how do the primary care providers regulate the access of the patients to the very expensive hospital and specialist services that account for such a large portion the total cost?

This corresponds, then, to my typology for characterizing the health services systems that I am looking at in terms of three kinds of institutional arrangements. What is the nature of the funding agency? What is the nature and the organization of the provision of primary care — the services of family doctors, general practitioners, or primary care in general? How are hospitals, specialists, and medical services funded? How is the access of patients to hospital services and the services of specialists regulated?

Recently, a couple of issues have become much more important — and perhaps my typology should be updated. There is the issue of pharmaceuticals, which, as you may know, at the present time actually in the aggregate costs as much as the total amount spent on physician services in the Canadian system. How is the utilization of pharmaceuticals determined, and what explains the very rapid increase in cost of pharmaceuticals in some countries?

Obviously, there is also an emerging issue in respect of an aging population — long-term care and nursing home care — and what determines the rate of change in the cost of those kinds of services.

To illustrate how this typology is used in characterizing the health services systems, I will reiterate how the Canadian system is organized in those terms.

As far as the insurance or funding is concerned, we have a single public tax-financed plan; as to the relationship between the insured and the insurer or the funding agency, we have zero user fees. I have shown a last line that indicates “quality of coverage.” I hesitated for a long time whether to include a question mark

y compris en Grande-Bretagne, les patients ont une certaine marge de manoeuvre, même s’il s’agit essentiellement d’un régime public.

Les arrangements institutionnels deviennent aussi exceptionnellement importants pour les rapports entre l’agence de financement, c’est-à-dire le gouvernement ou le régime d’assurance d’une part, et ceux qui fournissent les services aux clients assurés de l’autre. Cela touche des questions comme les taux versés aux fournisseurs, la façon dont ces taux sont fixés, que ce soit par la concurrence ou que les prix soient réglementés et négociés, et l’inclusion des soins gérés, comme on le voit de plus en plus aux États-Unis. Autrement dit, les assureurs imposent-ils des règles pour contrôler la façon dont les fournisseurs assurent les services aux utilisateurs?

Une autre question bien importante a trait au lien entre les fournisseurs de soins primaires, c’est-à-dire les médecins de famille ou généralistes qui représentent la première ligne de défense d’un régime de services de santé ou le premier point de contact entre le patient et le régime, et ceux qui fournissent ce qui représente la partie la plus coûteuse et de loin du budget total des services de santé, soit les services hospitaliers et les services de spécialistes. Autrement dit, comment les fournisseurs de soins primaires réglementent-ils l’accès des patients aux services hospitaliers et spécialisés très coûteux qui représentent une partie si importante du coût total?

Cela correspond à la classification typologique que j’ai établie pour décrire les régimes de services de santé comme appartenant à trois genres d’arrangement institutionnel. Quelle est la nature de l’agence de financement? Quelle est la nature et l’organisation des services de soins primaires, c’est-à-dire les services de médecins de famille, de généralistes ou les soins primaires en général? Comment les hôpitaux, les spécialistes et les services médicaux sont-ils financés? Comment réglemente-t-on l’accès des patients aux services hospitaliers et aux services de spécialistes?

Récemment, d’autres questions ont acquis beaucoup plus d’importance et je devrai peut-être mettre ma classification typologique à jour. Il y a la question des produits pharmaceutiques qui, comme vous le savez peut-être, représentent maintenant une aussi grande partie des coûts totaux que le temps consacré aux services de médecins dans le régime canadien. Comment détermine-t-on quel produit pharmaceutique utiliser et comment expliquer l’augmentation très rapide du coût des produits pharmaceutiques dans certains pays?

Bien entendu, il y a aussi la question de la population vieillissante, c’est-à-dire les fournisseurs de soins de longue durée et de soins en maison de repos et ceux qui déterminent l’évolution du coût des services de ce genre.

Pour montrer comment j’utilise cette classification typologique pour décrire les régimes de services de santé, je reviens à la façon dont le régime canadien est organisé.

Sur le plan de l’assurance ou du financement, nous avons un régime public unique financé par les impôts et, sur le plan des rapports entre l’assuré et l’assureur ou l’agence de financement, il n’y a pas de ticket modérateur. J’ai inclus une dernière ligne qui montre la qualité de l’assurance. Je me suis longtemps demandé

after “quality of coverage,” but the issue relates to waiting times under the plan, access to the most advanced technology under the plan, and so forth. In other words, what can we say about the quality of the insurance coverage that we implicitly have under the Canadian system in comparison with the coverage that other people have in other systems?

Primary care in Canada is provided by family doctors or general practitioners, as the British terminology is, who are paid in accordance with the principle of fee for service. I assume that everyone knows that “fee for service” simply means that when a patient goes to the doctor a schedule is consulted at the end of the visit, and the schedule indicates the fee for each service that was provided to that patient. That dollar amount, then, is the basis for the doctor’s income, when the billing takes place, of the provincial insurance plan, monthly.

It is also, of course, the case, though I have not listed it here, that a considerable portion of primary care in the Canadian system is now supplied through hospital emergency rooms. As you know, from the viewpoint of public policy, an important issue is the question of what the appropriate role of provision of primary care through emergency rooms should be.

With respect to hospitals and specialist care, Canada has a system where even hospital-based specialists — the ones who treat their patients in hospital — are paid on the same fee-for-service basis as primary care providers. In that respect, Canada differs from many other countries where the payment to hospital-based specialists is different. In part, this is because there is always an ambiguous economic relationship between fee-for-service reimbursed specialists and the very expensive infrastructure facilities that they need in order to earn their living, namely, the hospital facilities that they need to treat their patients. What incentives do we have to ensure that there is an efficient combination of the use of specialist services and the very expensive component of the health care system that hospitals represent when the payment is from two different pies? Hospitals get paid directly from provincial ministers of health, whereas the doctors that work in the hospitals get paid from a different budget.

Let me say a few words about how a couple of the countries on my list differ, in terms of this organization, from the Canadian system. Remember that the U.K. system is much less expensive than the Canadian one. We spend 9 per cent of our GNP on health services. The British spend something like 7 per cent of a smaller GDP; thus, they have a health services system that is less expensive than ours. Whether the quality is the same is a different question, of course, but at least it is a lot cheaper.

As far as insurance is concerned, the U.K. system is similar to the Canadian one in the sense that there is public, single plan coverage. It is financed out of taxes. There are no user fees for NHS services in the United Kingdom. As far as I am aware, the United Kingdom and Canada make up the list of countries that have zero user fees for everything. Most other countries do have

s’il fallait mettre un point d’interrogation après qualité de l’assurance, mais cette question a trait aux périodes d’attente, à l’accès aux technologies les plus perfectionnées, et ainsi de suite. Autrement dit, que peut-on dire à propos de la qualité de l’assurance que nous avons implicitement selon le régime canadien par rapport à l’assurance offerte dans d’autres régimes?

Au Canada, les soins primaires sont fournis par les médecins de famille ou généralistes, comme on les appelle en Grande-Bretagne, qui sont payés selon le principe du paiement à l’acte. J’imagine que tout le monde sait que le «paiement à l’acte» signifie simplement que, lorsqu’un patient va voir le médecin, on consulte un barème à la fin de la visite où l’on trouve le montant du paiement pour chaque service fourni au patient. C’est d’après ce montant qu’on calcule le revenu du médecin tous les mois quand on facture le régime d’assurance provinciale.

Bien entendu, même si je ne l’indique pas ici, une partie importante des soins primaires au Canada sont maintenant fournis à l’hôpital aux salles d’urgence. Comme vous le savez, une question importante sur le plan de la politique publique consiste à savoir quel rôle devraient jouer les salles d’urgence pour la fourniture de soins primaires.

Relativement aux services hospitaliers et spécialisés, selon le système canadien, même les spécialistes dans les hôpitaux, c’est-à-dire ceux qui traitent leurs malades à l’hôpital, sont rémunérés en fonction du même système de paiement à l’acte que les fournisseurs de soins primaires. Le régime canadien s’écarte sur ce plan du régime de bien d’autres pays où les spécialistes hospitaliers sont rémunérés autrement. Cela vient en partie du fait qu’il y a toujours un rapport économique ambigu entre les spécialistes rémunérés à l’acte et les installations très dispendieuses dont ils ont besoin pour gagner leur vie, c’est-à-dire les installations dont ils se servent pour traiter leurs patients à l’hôpital. Quels incitatifs avons-nous pour garantir une combinaison efficace de l’utilisation des services de spécialistes et l’élément très dispendieux du régime de soins de santé représenté par les hôpitaux si le paiement vient de deux endroits différents? Les hôpitaux sont payés directement par les ministres provinciaux de la Santé alors que la rémunération des médecins travaillant dans ces hôpitaux vient d’un autre budget.

Je voudrais dire quelques mots au sujet des différences qu’il y a entre le régime de certains des pays sur ma liste et le régime canadien relativement à cette organisation. Il ne faut pas oublier que le régime britannique est beaucoup moins dispendieux que le régime canadien. Nous dépensons 9 p. 100 de notre PNB pour les services de santé alors que les Britanniques y consacrent quelque chose comme 7 p. 100 d’un PIB moins important. Leur régime de soins de santé est donc moins dispendieux que le nôtre. Reste à savoir si la qualité est la même, bien sûr, mais le régime britannique coûte de toute façon beaucoup moins cher.

Pour ce qui est de l’assurance, le système du Royaume-Uni est semblable à celui du Canada en ce sens qu’il s’agit d’un régime public universel. Il est financé par l’argent des impôts. Il n’y a pas de ticket modérateur pour obtenir des services de santé au Royaume-Uni. À ma connaissance, le Royaume-Uni et le Canada sont les seuls pays où tous les soins sont entièrement gratuits. La

user charges, but the United Kingdom and Canada do adhere to the policy of zero user fees.

Contrary to the Canadian case, there is a substantial private insurance sector in the United Kingdom, under which about 10 per cent of the population has private coverage, contrary to the case in Canada. I think it is illegal in all provinces for private insurers to offer plans that cover the same things that are covered under the public plan. In the United Kingdom, there is no such prohibition; as a result, there is a substantial private insurance sector in the United Kingdom.

Note, however, that in the terminology that I like to use, anyone in the United Kingdom who has private insurance has in fact paid twice for health insurance. First, they have paid the taxes that entitle them to the services under the NHS. On top of that, they have paid the insurance premium that is giving them private coverage. There is no opting out in Britain. If you buy private coverage, you still have to pay the taxes to belong to the NHS. In that sense, private insurance does remain relatively small in the United Kingdom for that reason, in part.

From the viewpoint of lessons for Canada, perhaps the most important difference is the system used in the United Kingdom to pay for the services of primary care. In the United Kingdom, primary care is provided by general practitioners who operate under a contract with the ministry of health. I am not sure technically if it is contract with the NHS, or with the government, but it is a contract with the public sector.

Each general practitioner in the United Kingdom receives payment at the end of each month dependant solely on the number of individuals who are signed up with that doctor over the month; payment is not made according to the volume of services that the doctor has provided for those patients. Payment is based on the number of people on the doctor's list regardless of the volume of services that the doctor has provided.

In order for such a system to function, it must be the case that any given patient can be signed up at any time only with one doctor. It also has to be the case, in order for the British system to work, that every patient has to be signed up with one doctor. The rule, or system, that regulates this is referred to as "gatekeeping," under which you cannot have access to hospital services or pharmaceuticals, or any other services offered covered under the NHS, except under referral of your general practitioner. Thus, patients have an incentive to ensure that they are signed up with a general practitioner in order to assure that they do retain access to other services under the NHS.

There is an important feature of a system of capitation in the viewpoint of an economist. In a fee-for-service system, doctors have a financial incentive to provide a large volume of services, because the larger the volume of services they provide the more money they make. In a system of capitation, the doctor has no such incentive. The amount of money paid monthly to a doctor is independent of the number of units of service that is provided to patients.

plupart des autres pays imposent un ticket modérateur, mais le Royaume-Uni et le Canada n'en ont pas.

Contrairement à la situation au Canada, il y a un important secteur de l'assurance privée au Royaume-Uni où environ 10 p. 100 de la population est couverte par une assurance privée contrairement à ce qui se passe ici. Je crois que, dans toutes les provinces, il est interdit aux assureurs privés d'offrir des régimes d'assurance couvrant les mêmes choses que le régime public. Cette interdiction n'existe pas au Royaume-Uni si bien que le secteur de l'assurance privée y est important.

Je signale toutefois qu'au Royaume-Uni, ceux qui souscrivent une assurance privée paient deux fois pour leur assurance-santé. D'abord ils paient les impôts qui leur donnent droit aux services du régime public. Ensuite, ils doivent payer la prime pour leur assurance privée. Vous n'avez pas d'option de retrait. Si vous achetez une assurance privée, vous devez quand même payer les impôts qui financent le régime public. L'assurance privée reste donc relativement limitée au Royaume-Uni pour cette raison.

Pour ce qui est des leçons que le Canada pourrait en tirer, la principale différence réside sans doute dans le système utilisé au Royaume-Uni pour payer les services de soins primaires. Ces soins sont fournis par les médecins généralistes qui travaillent sous contrat pour le ministère de la Santé. Je ne sais pas exactement s'il s'agit d'un contrat avec le Service national de la santé ou avec le gouvernement, mais c'est un contrat avec le secteur public.

Chaque médecin généraliste du Royaume-Uni reçoit, à la fin du mois, un paiement qui dépend uniquement du nombre de personnes enregistrées auprès de ce médecin au cours du mois; la rémunération ne dépend pas du volume de services fournis à ces patients. Le paiement se fonde sur le nombre de personnes que le médecin a sur sa liste, quel que soit le volume de services fournis.

Pour que ce genre de système fonctionne, il faut qu'un patient ne puisse s'inscrire que chez un seul et même médecin. Le système de régulation est un «barrage» qui ne vous permet pas d'avoir accès à des services hospitaliers, à des médicaments ou à d'autres services couverts par le régime public, à moins d'être dirigé vers ces services par votre médecin généraliste. Ce système incite les patients à s'inscrire auprès d'un généraliste afin d'être certain d'avoir accès aux autres services.

Un système de capitation présente une caractéristique importante du point de vue d'un économiste. Le paiement à l'acte incite les médecins à offrir un volume de services important, car plus ce volume augmente, plus ils gagnent d'argent. Dans un système de capitation, le médecin n'a pas ce genre d'incitatif. Le montant d'argent qui lui est versé chaque mois ne dépend pas du nombre d'unités de service qu'il fournit aux patients.

Notice, also, that there is an important feature here, one that is necessary for the system to function: Patients do have the right from time to time to switch from one GP to another if they are not happy the GP with whom they are currently signed.

Senator Carstairs: One question. How do they make use of emergency services under the capitation?

Mr. Blomqvist: As far as I am aware, there are no provisions for substituting. You must be on a primary care provider's list in order to have access to any kind of hospital service or pharmaceutical. As far as I am aware, there are no lists for emergency departments, which means that, presumably, you can get treated at an emergency department in an emergency, if your GP is not available or whatever. I would assume that the GP contracts probably do provide for backup services, such as is currently being debated in Canada. However, I am not familiar with the exact details of that.

Ms Colleen Flood, Professor, University of Toronto: Most of them do not cover emergency care. They do not cover emergency care, so people can access emergency services just as they do here.

The Chairman: Emergency care is really treated outside the system, literally as something you treat specially because it is an emergency.

Ms Flood: However, some GP clinics are setting up side by side with accident emergency clinics to try to encourage people to go there first, rather than going to the hospital.

Mr. Blomqvist: Regarding hospital care, they have a system similar to the Canadian one in some respects, when it comes to the decision as to which hospital gets how much money. The decision is basically an administrative one within the management of the NHS. I characterized it in my paper as a political decision in the Canadian system. The difference in the U.K. is that specialists who work in the hospitals are salaried employees of the hospitals. The ambiguity to which I referred vis-à-vis the economic relations between the hospital-based specialists and the hospitals in which they work that we have in the Canadian system does not exist in the same form in the United Kingdom. The specialists in the U.K. who work in hospitals are salaried employees of the hospital. I do not know of a study of how that changes the dynamics of decision making between the hospital managers and the doctors, but it would seem to me that it is likely to change that dynamic in a very substantial fashion.

In the interests of time, I will not say anything much about the reforms in the United Kingdom. My written submission does go into some details about those reforms. I think they are extremely interesting, but perhaps Ms Flood will say a few words about that.

The Netherlands is a very interesting case, perhaps not so much because of the way the health services system is in fact organized at the present time but because of the extremely comprehensive proposal for reforming the Dutch health services system that

Remarquez également que ce système présente une caractéristique importante qui est nécessaire à son bon fonctionnement. Les patients ont en effet le droit de changer de généraliste s'ils ne sont pas satisfaits de celui auprès duquel ils sont inscrits.

Le sénateur Carstairs: J'ai une question. Comment les patients peuvent-ils recourir aux services d'urgence avec le système de capitation?

M. Blomqvist: À ma connaissance, il n'y a pas de dispositions de remplacement. Vous devez être inscrit sur la liste d'un fournisseur de soins primaires pour avoir accès à des services hospitaliers ou pharmaceutiques. À ma connaissance, il n'y a pas de listes pour les services d'urgence, ce qui veut dire qu'en principe vous pouvez vous faire soigner à l'urgence si votre généraliste n'est pas disponible. Je suppose que le contrat du généraliste prévoit sans doute des services d'appoint, comme ceux dont on discute actuellement au Canada. Toutefois, je ne connais pas tous les détails.

Mme Colleen Flood, professeure, Université de Toronto: La plupart des médecins n'assurent pas les soins d'urgence. Les gens peuvent donc avoir accès aux services d'urgence comme c'est le cas ici.

Le président: Les soins d'urgence sont dispensés en dehors du système. Comme il s'agit d'une urgence, c'est considéré comme des soins à part.

Mme Flood: Toutefois, certaines cliniques de médecine générale sont établies à côté de cliniques d'urgence pour inciter les gens à se présenter là en premier au lieu de se rendre à l'hôpital.

M. Blomqvist: Pour ce qui est des soins hospitaliers, le système britannique est comparable au système canadien à certains égards pour ce qui est de la répartition des fonds entre les hôpitaux. Il s'agit avant tout d'une décision administrative prise par la direction du Service national de la santé. Dans mon mémoire, je dis que c'est une décision politique qui est prise dans le système canadien. La différence au Royaume-Uni est que les spécialistes qui travaillent dans les hôpitaux sont des employés salariés des hôpitaux. L'ambiguïté dont j'ai parlé en ce qui concerne les relations économiques qui existent au Canada entre les spécialistes des hôpitaux et l'établissement hospitalier dans lequel ils travaillent n'existe pas sous la même forme au Royaume-Uni. Les spécialistes du Royaume-Uni qui travaillent en milieu hospitalier sont des employés salariés de l'hôpital. Je ne connais pas d'étude indiquant de quelle façon cela change la dynamique des prises de décisions entre les gestionnaires des hôpitaux et les médecins, mais j'ai l'impression que cela doit changer cette dynamique dans une large mesure.

Pour gagner du temps, je ne parlerai pas vraiment des réformes apportées au Royaume-Uni. Mon mémoire fournit certains détails à ce sujet. Je les crois très intéressants, mais Mme Flood voudra peut-être vous en parler.

Le cas des Pays-Bas est très intéressant, peut-être pas tant en raison de la façon dont les services de santé sont organisés pour le moment, mais plutôt en raison du projet de réforme extrêmement complet qui a été lancé au début des années 90. Nous ne savons

existed in the early 1990s. It is not clear how far that reform has progressed. There is considerable political wrangling at the present time in the Netherlands. It was a very interesting set of reform proposals.

The key thing there was that what the Dutch were prepared to do under this reform proposal was basically move from pretty much a unitary system of public health insurance, at least for people with low incomes, to a system where everyone would be insured on a compulsory basis. However, there would be a number of competing managed-care plans in Holland through which people could get their public insurance.

The funding would continue to be basically government funding, with a small private premium component. However, the public funding was going to be made available to various insurance plans, which would compete for the public funding. This is referred to as managed competition. I refer to it as managed competition among multiple managed-care plans.

The Chairman: As you have described that, that is exactly what a voucher system is. It is the same as that which one hears about with respect to a voucher system for education.

Mr. Blomqvist: That is exactly right. It is also very similar, for those of you who followed the shenanigans in United States in the mid-1990s, to a version of the Clinton plan. This is not completely an accident, because the health economist whose name is most often mentioned as the originator of the Clinton plan is Alain Enthoven, who turns out to be of Dutch ancestry and was intimately involved in consulting with the Dutch when they formulated their plan.

The current form of the Dutch system does provide an interesting piece of empirical evidence for those in Canada who claim that a system that mixes private and public insurance will inevitably lead to an inadequate standard of public insurance. In Holland, something like a little over 60 per cent of the population, those with low incomes, are covered through a universal public plan, whereas everyone above that income level or who is self-employed has to get private insurance if they want to have any health insurance at all.

Given that patients are treated in hospitals both from the public plans and the private plans, and there are physicians who treat individuals both from the public and private plans, this does provide a test case for those Canadians who claim that introducing any element of private insurance will inevitably lead to a decline in the standards of the public plan. I am not sure of comparisons that have systematically addressed this issue, but since the Dutch system is a relatively stable one that seems to have a substantial amount of political support it would seem, at least on the face of it, that this is an example of a system where private and public coverage coexist, and it has not led to the demise of the public system.

I will stop there. Let me simply refer to the additional material that is contained in my written submission. I talk there a bit about the American Medicare plan, and what I wanted to do was basically ask the question: If you had a medicare plan such as the

pas exactement où en est cette réforme. Il y a à l'heure actuelle énormément de conflits politiques aux Pays-Bas. Il s'agissait d'un projet de réforme très intéressant.

Disons surtout que les réformes que les Hollandais s'appropriaient à apporter consistaient essentiellement à passer d'un régime d'assurance-santé public unitaire, du moins pour les personnes à faible revenu, à un régime d'assurance obligatoire pour tout le monde. Les gens seraient couverts par l'entremise d'un certain nombre de régimes de soins gérés qui se feraient concurrence.

Le gouvernement continuerait d'assurer le financement du régime avec une petite participation du secteur privé. Toutefois, le financement public devait être étendu à plusieurs régimes d'assurance qui allaient se concurrencer pour obtenir cet argent. C'est ce qu'on appelle une concurrence gérée. J'appelle cela une concurrence gérée entre divers régimes de soins gérés.

Le président: D'après votre description, cela correspond exactement à un système de coupons. C'est la même chose que le système de coupons dont on parle en ce qui concerne l'éducation.

M. Blomqvist: C'est tout à fait cela. De plus, ceux d'entre vous qui ont suivi ce qui s'est passé au milieu des années 90 aux États-Unis remarqueront que cela ressemble beaucoup à une version du plan Clinton. Ce n'est pas vraiment accidentel, étant donné que l'économiste de la santé dont le nom revient le plus souvent lorsqu'on parle de celui qui est à l'origine du plan Clinton, c'est le nom d'Alain Enthoven, d'origine hollandaise, qui a été consulté à maintes reprises par les Hollandais, au moment où ceux-ci préparaient leur propre régime d'assurance.

La forme actuelle du régime hollandais fournit une preuve empirique intéressante pour les Canadiens qui affirment qu'un système de soins qui mêlerait assurance publique et assurance privée mènera inévitablement à une baisse des normes dans l'assurance publique. En Hollande, un peu plus de 60 p. 100 de la population, c'est-à-dire ceux qui ont des bas revenus, sont assurés par le régime public universel, tandis que tous ceux qui dépassent un certain seuil de revenu, ou qui sont à leur propre compte, doivent se tourner vers le privé pour obtenir une assurance-santé.

Comme les patients des régimes public et privé sont tous traités dans les hôpitaux et que les médecins s'occupent des deux types de patients, cela pourrait servir de cause type pour les Canadiens qui affirment que l'introduction de l'assurance privée dans les soins de santé mènera inévitablement à un abaissement des normes du régime public. Je ne suis pas sûr que l'on a systématiquement cherché à comparer les deux systèmes, mais étant donné que le régime hollandais est relativement stable et être semble appuyé en bonne partie par la classe politique, il semblerait à première vue que l'on puisse y trouver l'illustration de la coexistence pacifique des régimes public et privé, coexistence qui n'a pas entraîné l'effondrement du système public.

Voilà ce que j'avais à dire. Sachez aussi que mon mémoire écrit comprend des documents supplémentaires dans lesquels je parle un peu du régime américain Medicare. Au fond, ce que je fais, c'est poser la question suivante: si l'on avait un régime

plan that covers every American over 65 in the United States, and if you made the United States a country of universal health insurance, publicly financed and arranged, simply by expanding the coverage of their Medicare plan to the entire population, how different would that system look from the system that we currently have in Canada?

Mr. Stabile will focus on that comparison, so I will simply end there.

Mr. Mark Stabile, Professor, University of Toronto: As Professor Blomqvist said, I will speak only about the American and Canadian health insurance systems.

While the majority of Americans receive their health insurance through private insurance plans, offered primarily through their place of employment, a substantial number of Americans also qualify for public insurance. The two largest public insurance programs in the United States are the Medicare program, which serves individuals aged 65 and over, as well as the disabled and people with permanent kidney failure, and the Medicaid program, which serves the poor. The Medicare program is a federally run program while the Medicaid program is run by individual states. Twenty-five per cent of Americans claim either Medicare or Medicaid as their primary source of health insurance.

I will focus on the Medicare program because of the useful comparisons that can be drawn between that program and Canada's public health insurance system. Of course, as was noted, one major difference in the two programs is that Medicare primarily serves the elderly, who use considerably more health care resources than the general population. Also, as you know, the Canadian health insurance system has universal access.

Almost all Americans aged 65 and over are eligible for Medicare. In 1998, 35.5 million people were enrolled in traditional fee-for-service Medicare, and an additional 4.2 million were enrolled in a managed-care Medicare program. It is interesting to note that the total population covered by Medicare actually exceeds that covered by all the provincial health care programs in Canada combined.

Medicare consists of two parts, A and B. Part A primarily finances in-patient hospital services; Part B helps pay for the cost of physician services, out-patient hospital services, and medical equipment. Part B is optional, but almost everyone takes it. In 1998, 97 per cent of people enrolled in Part A were also enrolled in Part B.

As noted, the program is primarily financed through taxes on employees and employers, as well as through general revenues and some small additional premiums. Let me quickly talk about those premiums. There is no premium for Part A. The 2000 rate for Part B is a premium of U.S. \$45.50 per month. There are also deductibles and co-payments, and they actually can be quite large. There are also items that are not covered at all by traditional

d'assurance-médicaments tel que le régime qui s'applique à tous les Américains de plus de 65 ans, et si le régime d'assurance-santé américain devenait universel et qu'il était financé par les deniers publics parce qu'il s'adresse à l'ensemble de la population américaine, jusqu'à quel point ce système différerait-il de celui qui existe actuellement au Canada.

Je m'arrêterai ici, puisque M. Stabile reprendra la comparaison.

M. Mark Stabile, professeur, Université de Toronto: Comme le disait M. Blomqvist, je m'en tiendrai aux deux régimes d'assurance-santé du Canada et des États-Unis.

Tandis que la majorité des Américains adhère à des régimes privés d'assurance-santé, qui leur sont offerts principalement par leur employeur, un grand nombre d'Américains ont également droit à l'assurance publique. Aux États-Unis, les deux plus grands régimes d'assurance publique sont le programme Medicare, qui s'applique à tous les Américains de plus de 65 ans, de même qu'aux handicapés et aux Américains qui souffrent d'une insuffisance rénale permanente, et le programme Medicaid, qui s'adresse aux pauvres. Le programme Medicare est un programme fédéral, tandis que le programme Medicaid est géré par les différents États. Vingt-cinq pour cent des Américains affirment que Medicare ou Medicaid est leur source principale d'assurance-santé.

Je vais m'attarder au programme Medicare, puisqu'il est possible de faire des comparaisons utiles entre Medicare et le régime canadien d'assurance-santé publique. Comme on l'a signalé, la grande différence entre les deux programmes, c'est que Medicare s'adresse principalement aux personnes âgées qui font appel aux ressources de santé beaucoup plus souvent que l'ensemble de la population. Par ailleurs, comme vous le savez, le régime d'assurance-santé du Canada est universel d'accès.

Presque tous les Américains de 65 ans et plus sont assurés par Medicare. En 1998, 35,5 millions d'Américains étaient inscrits au régime Medicare traditionnel de rémunération à l'acte, et 4,2 millions de plus étaient inscrits au régime Medicare de soins gérés. Il est intéressant de noter que l'ensemble de la population assurée par Medicare dépasse le nombre de Canadiens assurés par tous les programmes provinciaux de soins de santé au Canada, toutes provinces combinées.

Le régime Medicare est en deux parties. La partie A sert principalement à financer les services aux hospitalisés. La partie B aide à payer le coût des services des médecins, les soins en clinique externe et l'équipement médical. La partie B est facultative, mais presque tout le monde y adhère. En effet, en 1998, 97 p. 100 de ceux qui avaient adhéré à la partie A du régime avaient également adhéré à sa partie B.

Comme on l'a mentionné, le programme est financé principalement par les taxes perçues auprès des employés et des employeurs, de même que grâce aux recettes générales et à de petites primes supplémentaires. Laissez-moi vous parler rapidement de ces primes. Il n'y a aucune prime à payer pour adhérer à la partie A. Par contre, les taux d'adhésion à la partie B du régime pour l'an 2000 représentent 45,50 \$ US par mois. Le

fee-for-service Medicare, and perhaps the largest expense would be prescription drugs purchased outside the hospital.

The U.S. has a private insurance market that works alongside Medicare. It allows individuals to insure themselves against some of the costs involved with using the Medicare system and against items such as prescription drugs that are not covered under Medicare. This type of insurance is referred to as medigap insurance, so-called because it fills the gaps in Medicare.

State-run insurance departments approve medigap policies, which are then sold by private insurance companies. Medicare-eligible Americans generally purchase medigap in one of two ways. They either purchase it individually on the private market or they receive it from the current or former employer. Sixty-six per cent of the fee-for-service Medicare recipients have medigap coverage, and about half of those with medigap coverage receive it from a current or former employer.

Many individuals choose to purchase their policy through an employer because employer contributions to employee health care policies are exempt from the taxable income of employees. An extensive amount of research in the U.S. shows that these tax subsidies not only encourage individuals to purchase insurance through an employer, but also they encourage people to buy more insurance than they otherwise would.

What medigap does essentially is reduce the out-of-pocket cost of using the health care system. Individuals with medigap coverage face fewer out-of-pocket costs when using the health care system than do individuals without medigap coverage. If people respond to price incentives, we might expect, then, that individuals with private medigap insurance will not only use more of the services that are covered by medigap but will also use more of the services that are covered by Medicare, the public insurance program, since they face a lower out-of-pocket cost of doing so. Studies in the U.S. support this hypothesis. In a study by the Congressional Budget Office, researchers found that private medigap holders use 24 per cent more in-patient hospital and physician services, those services covered by Medicare, than did individuals who did not have medigap.

I want to draw, then, some parallels between the Medicare-medigap situation in the U.S. and our provincial health care system here in Canada. Like U.S. Medicare, each of the provinces has public insurance, which covers hospital and physician services. Unlike U.S. Medicare, these services are

régime prévoit également des franchises et une participation aux coûts, qui peuvent être toutes deux assez imposantes. Il y a également des services qui ne sont pas assurés par le régime Medicare traditionnel de rémunération à l'acte, et les médicaments d'ordonnance achetés à l'extérieur de l'hôpital constituent sans doute la dépense la plus impressionnante en ce sens.

Les États-Unis ont un marché de l'assurance privée qui fonctionne en parallèle avec Medicare; cela permet aux individus de s'assurer contre certains des coûts afférents à l'utilisation du régime Medicare et contre certains frais comme ceux des médicaments d'ordonnance qui ne sont pas assurés par Medicare. C'est ce que l'on appelle là-bas l'assurance «medigap», qui sert à combler les lacunes du régime Medicare.

Les départements d'assurance des différents États approuvent les polices d'assurance qui servent à combler les lacunes dont je viens de parler, polices qui sont ensuite vendues par des compagnies d'assurance privées. Les Américains admissibles à Medicare achètent généralement des polices supplémentaires selon deux options: ils l'achètent soit sur une base individuelle sur le marché privé ou la reçoivent de leur employeur actuel ou précédent. Soixante-six pour cent des assurés du régime Medicare selon la rémunération à l'acte ont une assurance supplémentaire pour combler les lacunes de la première, et environ la moitié de ceux qui ont cette assurance supplémentaire la reçoivent de leur employeur précédent ou actuel.

Beaucoup d'Américains choisissent d'acheter leur police par le truchement de leur employeur, car les contributions de l'employeur aux polices de soins de santé de l'employé sont exclues du revenu imposable de l'employé. De nombreuses recherches effectuées aux États-Unis démontrent que ces subventions à caractère fiscal non seulement encouragent les individus à acheter de l'assurance par le truchement de leur employeur, mais les encouragent aussi à se procurer une couverture plus importante qu'ils ne l'auraient fait autrement.

Ce que fait le régime «medigap», c'est qu'il réduit le montant à déboursier chaque fois que l'on utilise le système de soins de santé. Il en coûte moins cher à ceux qui ont une assurance «medigap» de recourir au système de soins de santé que ceux qui n'en ont pas. Si les gens réagissent à l'incitation par les prix, on peut alors s'attendre à ce que ceux qui ont de l'assurance privée «medigap» non seulement utiliseront plus souvent les services assurés par le medigap mais auront également plus souvent recours aux services assurés par Medicare, le régime d'assurance publique, étant donné qu'ils ont moins de déboursés à faire chaque fois qu'ils y ont recours. Les études effectuées aux États-Unis viennent étayer cette hypothèse. Dans l'une d'entre elles effectuée par le Congressional Budget Office, les chercheurs ont constaté que les détenteurs d'assurance privée «medigap» utilisaient 24 p. 100 de plus que ceux qui n'avaient pas cette assurance les services d'hospitalisation et les services de médecin, qui sont assurés par Medicare.

J'aimerais faire certains parallèles entre le cas de Medicare-medigap aux États-Unis et notre système provincial de soins de santé au Canada. Tout comme pour Medicare aux États-Unis, chacune des provinces offre un régime d'assurance publique qui s'applique aux services dans les hôpitaux et aux

available to the entire population, not just to a targeted segment of the population. The provinces offer first-dollar coverage. As was noted, there are no direct deductibles or co-payments required when using the health care system. However, as with U.S. Medicare, there are items that are not covered by provincial plans but which are becoming an increasingly important part of health care. Prescription drugs purchased outside the hospital make up a large part of these costs, but there are several other items as well. These items are out-of-pocket costs associated with using the health care system, and although they are not labelled co-payments they serve essentially the same role, which is to share the cost of health care between the user and the insurer.

For example, if you go to the doctor because of a sore throat and find out you have strep throat, the doctor can diagnose your illness but you will require antibiotics at private expense to effectively treat it. The Ontario Health Insurance Plan will cover one standard eye doctor's visit every two years, but purchasing prescription lenses plays a large part in correcting your vision.

As a result, many Canadians acquire supplemental health insurance to cover some of the items not covered under the provincial health care plan. In 1996, close to 60 per cent of Canadians claimed some form of supplemental health coverage, and I understand that number is now over 70 per cent.

Most Canadians purchase this insurance through an employer, and about 60 per cent of working Canadians claim that their employer offers them some kind of benefit such as this. There is evidence to suggest that one reason this might be the case is because of some subsidies similar to the U.S. that are offered if you purchase this health insurance plan through an employer.

Economists who study the insurance industry have found that individuals behave differently when they have insurance than when they do not. Since individuals face fewer out-of-pocket costs when they have insurance, they may use those services covered by the insurance more often. Likewise, an individual without insurance coverage who faces a higher cost for a particular service will use it less often.

I would point out that like the Medicare/medigap system in the United States, the public health insurance system and the private supplemental insurance system in Canada complement each other and for the most part do not act as substitutes for one another. We are effectively cost sharing our health care expenditures by bundling goods and services, some publicly financed and some privately financed. As previously noted, perhaps the clearest example of this is bundling publicly financed doctor services with privately financed prescription drugs.

services des médecins. Mais contrairement à Medicare américain, ces services sont offerts à la totalité de la population et pas seulement à un segment de celle-ci. De plus, les provinces offrent une couverture au premier dollar. Comme on l'a signalé, lorsque l'on utilise le système de soins de santé, il n'y a pas de franchises directes ni de participation aux coûts. Toutefois, tout comme c'est le cas avec Medicare américain, certaines choses ne sont pas assurées par les régimes provinciaux, mais représentent une part accrue des coûts des soins de santé. Ainsi, les médicaments d'ordonnance achetés à l'extérieur de l'hôpital en représentent une très grande partie, tout comme plusieurs autres éléments. Ces éléments constituent des frais associés au système de soins de santé, et même s'ils ne sont pas considérés comme une participation aux coûts, ils jouent exactement le même rôle, à savoir qu'ils servent à partager les coûts des soins de santé entre l'utilisateur et l'assureur.

Ainsi, si vous allez voir le médecin parce que vous avez mal à la gorge et qu'il diagnostique une infection streptococcique, même si c'est le médecin qui a fait le diagnostic, il vous faudra acheter des antibiotiques à vos frais pour traiter votre maladie. De plus, la Régie de l'assurance-maladie de l'Ontario vous remboursera une visite tous les deux ans chez l'ophtalmologue, même si l'achat de verres de prescription sert surtout à corriger votre vision.

Par conséquent, beaucoup de Canadiens achètent de l'assurance-santé supplémentaire pour pouvoir acheter certains des éléments qui ne sont pas assurés par le régime provincial de soins de santé. En 1996, près de 60 p. 100 des Canadiens avouaient avoir acheté une assurance supplémentaire, et il semble que cette proportion ait maintenant grimpé à 70 p. 100.

La plupart des Canadiens achètent cette assurance par le biais de leur employeur, et quelque 60 p. 100 des Canadiens qui travaillent affirment que leur employeur leur offre un avantage comme celui-là. On peut démontrer que s'il en est ainsi, c'est peut-être à cause des subventions semblables à celles que l'on offre aux États-Unis lorsque l'on achète une assurance complémentaire par le truchement de son employeur.

Les économistes qui se sont penchés sur l'industrie de l'assurance ont constaté que les individus se comportent différemment lorsqu'ils ont une assurance, ou n'en ont pas. Étant donné que les individus assurés ont moins de déboursés à faire, ils ont tendance à utiliser les services assurés plus fréquemment. De la même façon, ceux qui n'ont pas d'assurance supplémentaire et qui doivent payer pour obtenir un service particulier y auront recours moins fréquemment.

Je voudrais signaler que tout comme dans le cas du système Medicare-medigap américain, le système d'assurance-santé publique et le système d'assurance supplémentaire privée qui existent au Canada se complètent et ne peuvent dans la plupart des cas se substituer l'un à l'autre. Nous partageons efficacement les coûts que représentent nos dépenses en soins de santé en regroupant les biens et services, dont certains sont financés par les deniers publics et d'autres financés par le privé. Comme on l'a déjà signalé, l'exemple le plus frappant est le regroupement des services de médecins financés par les deniers publics avec les médicaments d'ordonnance financés par les assureurs privés.

What effect does this bundling have on how people use the health care system? Some evidence shows that individuals with private supplemental health insurance in Canada not only use more privately funded services but also more publicly funded services. In particular, a study shows that Canadians who had supplemental health insurance visited the doctor 10 per cent more often than individuals who did not. This result holds even after we adjust for the fact that individuals who have supplemental health insurance tend to be wealthier than individuals without supplemental health insurance and for differences in how individuals access their own health status.

I would note in conclusion that the health care systems of both the United States and Canada are partially publicly financed and partially privately financed. Often these health care services are effectively bundled such that both private and public spending are required to obtain effective care. Differential access to private insurance results in differences not only in the use of privately financed care but also in the use of publicly financed care. It is important to note that prescription drugs, which are privately financed when purchased outside of the hospital, are the fastest growing component of the health care system.

The implication of the current cost-sharing arrangements in both the United States with the Medicare program and in Canada with its supplemental and public health insurance program is that the interactions between the two systems will play increasingly important roles in health care delivery both in the United States and in Canada.

Ms Flood: All developed countries, with the notable exception of the United States, have a common goal in mind with their health care systems, and that is to ensure that everyone has access to a comprehensive range of high quality services on the basis of need and not on the basis of ability to pay. That is basically the redistributive goal that most developed countries, apart from the United States, have. Despite this similar objective, countries differ significantly in what health services they include in the basket of care that they cover or the range of services they cover. They also differ in how they determine what is in and what is out of the public basket.

They also, as Professor Blomqvist has discussed, differ in terms of their configuration. For example, European countries like the Netherlands, France and Germany rely on social insurance and significant regulation of private insurers and private providers. They achieve their redistributive goal by regulating the heck out of private insurers. Another group of countries, like Canada, the U.K. and New Zealand, relies on government control of financing, what is known as the "single payor" model, to ensure access for everyone and to keep control of prices and utilization. Those are the two most common modes or models of financing.

Quel effet ce regroupement a-t-il sur ceux qui utilisent le système de soins de santé? Il a été démontré que les individus ayant acheté une assurance privée supplémentaire au Canada utilisent plus souvent non seulement les services privés mais aussi les services publics. L'étude a probablement démontré que les Canadiens qui jouissent d'une assurance-santé supplémentaire rendent visite à leur médecin 10 p. 100 de fois plus souvent que les autres. Ce résultat ne se dément pas, même si l'on tient compte du fait que les individus qui jouissent d'une assurance supplémentaire sont généralement plus à l'aise que ceux qui n'en ont pas et si l'on tient compte des différences avec lesquelles les individus évaluent leur propre santé.

Je vais terminer en signalant que les systèmes de soins de santé des États-Unis et du Canada sont à la fois financés partiellement par les deniers publics et par les sociétés privées. Il arrive souvent que les services de soins de santé soient regroupés de façon efficace et que les dépenses privées et publiques soient nécessaires pour que l'assuré obtienne des soins efficaces. Ces différences dans l'accès des uns à l'assurance privée se traduisent par des différences d'utilisation non seulement des soins privés mais aussi des soins publics. Il est important de signaler que les médicaments d'ordonnance, qui sont assurés par les compagnies privées lorsqu'ils sont achetés à l'extérieur de l'hôpital, sont la composante qui croît le plus rapidement dans le système de soins de santé.

Les ententes actuelles de partage des coûts qui existent aux États-Unis avec le régime Medicare, et au Canada avec les régimes d'assurance-santé publique et les régimes supplémentaires ont pour conséquence que l'interaction entre les deux régimes jouera un rôle accru dans la prestation des soins de santé, à la fois aux États-Unis et au Canada.

Mme Flood: Tous les pays industrialisés, à l'exception notoire des États-Unis, ont mis sur pied des régimes d'assurance-santé dans un but qu'ils ont tous en commun, soit de s'assurer que tous leurs citoyens ont accès à une gamme exhaustive de services de qualité supérieure en fonction de leurs besoins et non pas en fonction de leur capacité de payer. Voilà l'objectif de redistribution que partagent la plupart des pays industrialisés, à l'exception des États-Unis. Mais en dépit du fait qu'ils partagent cet objectif, il y a d'énormes différences d'un pays à l'autre dans le type de services de santé qui sont inclus dans la corbeille de soins et de services assurés. Il y a également divergence d'un pays à l'autre quant à la façon dont on détermine ce qui entre ou pas dans la corbeille publique.

Il y a également des différences dans la configuration des régimes, comme l'a signalé le professeur Blomqvist. Ainsi, les pays européens tels que les Pays-Bas, la France et l'Allemagne misent sur l'assurance sociale et sur une réglementation considérable des assureurs et des fournisseurs privés. C'est en réglementant à l'excès les assureurs privés que ces pays atteignent leur objectif de redistribution. D'autres pays, tels que le Canada, le Royaume-Uni et la Nouvelle-Zélande, se fient au gouvernement pour contrôler le financement — et c'est ce qu'on appelle le modèle du payeur unique — afin que tous les citoyens aient accès au régime de santé et afin de continuer à contrôler les prix et

The first really important point to note is that while we all think that health care reform is something that bugs the hell out of Canadians it actually bugs the hell out of everyone else in the developed world as well. Every health care system struggles with these issues all the time. This should come as no big surprise given the enormous complexity of health care systems, the size of the health care systems and all the vested interests that are involved in health care systems. Therefore, it is important and fabulous that you will actually be studying the different health care systems that exist because a detailed study will certainly inform the debate so far, which is much about ideology and very little about evidence.

Every health care system struggles with the same essential problem, I think, and that is essentially that your health care needs are limitless. What is "need"? It is a contextual and relative concept. I could spend all my resources trying to perfect my health. I could demand that society does that to improve my life expectancy. Really, there is no end to what I could have the medical system do for me.

Once we say that health care is so important that people should not be denied it because they cannot afford it, that they should not be denied it because they do not have the money, then we have the problem that because people do not have to pay they expect that all their health care needs, however those are defined, should be met. That is the basic problem that we have. We want, as a matter of access and as a moral matter, to provide everyone with health care, but then we have the problem that they want more and more and more.

Even more important than what individual patients want is the fact that they rely on physicians to tell us what our health care needs are. That is what we do. Doctors tell us what is wrong with us and then tell us what we need to fix it. They diagnose, and then they tell us what we need. This is the gatekeeper function that Professor Blomqvist mentioned. This is really the key problem. In most health care systems, physicians have absolutely no incentive to be sensitive to the cost of the services that they tell you we need. They are the ones who control the services, diagnose us, and tell us what we need. They have no incentive to be concerned about whether they tell you to have 600 lab tests, blood tests, go to the doctor, go to the specialist, come back again next week, nothing.

I have studied health care systems in detail in the U.K., New Zealand, the Netherlands and the United States. For a very small fee, you can buy my book. I am happy to answer any questions that you have about those systems. However, in this brief time, I want to just point out the unique features of the Canadian system and then move on to what are actually a bit more prescriptive comments than I normally make, which I have actually distributed to you. It is a piece I wrote for policy options about how to fix

l'utilisation des services. Il s'agit là des deux modèles de financement les plus courants.

Il faut d'abord noter que même si nous avons l'impression que la réforme du système de santé est un sujet qui tape sur les nerfs des Canadiens, sachez qu'il tape aussi sur les nerfs de tous dans les autres pays industrialisés. Chacun des régimes de soins de santé se heurte constamment à ces mêmes problèmes. Cela ne devrait pas vous surprendre, étant donné l'énorme complexité des régimes de soins de santé, la taille gigantesque du régime de santé et tous les intérêts en place. Par conséquent, j'avoue qu'il est merveilleux de voir que vous allez vous pencher sur les différents régimes de soins de santé qui existent dans le monde, car une étude détaillée ne peut que faire avancer le débat, qui s'est embourbé jusqu'à maintenant dans l'idéologie sans vraiment tenir compte des faits.

Tous les régimes de soins de santé luttent contre le même problème, qui est le suivant: nos besoins en soins de santé sont sans limite. Mais qu'est-ce qu'un besoin? C'est une notion relative et qui dépend des contextes. Personnellement, je pourrais consacrer toutes mes ressources à essayer d'améliorer ma santé, et je pourrais exiger de la société qu'elle le fasse aussi pour prolonger mon espérance de vie. En fait, je pourrais exiger à peu près n'importe quoi du système médical.

Dès lors que l'on affirme que les soins de santé sont à ce point importants que l'on ne devrait les refuser à personne pour cause d'incapacité de payer, on se retrouve avec le problème suivant: du simple fait que l'on ne demande pas aux citoyens de payer, ils s'attendent à ce que le système réponde à tous leurs besoins en matière de soins de santé, peu importe comment ils sont définis. Voilà le problème fondamental. Nous voulons assurer l'accès à des soins de santé à tous, par principe moral, mais tous autant qu'ils sont en exigent plus, et plus encore.

Non seulement les patients exigent toujours plus, mais ils s'attendent à ce que leur médecin leur dicte leurs besoins en matière de soins de santé. C'est en effet courant. Nous nous tournons vers les médecins pour qu'ils nous disent ce qui cloche et pour nous dire comment retrouver la santé. Ce sont eux qui établissent le diagnostic et nous disent ce dont nous avons besoin. Il s'agit là de la fonction de contrôleur dont parlait M. Blomqvist, et c'est ce qui constitue le problème fondamental. Dans la plupart des systèmes de soins de santé, rien n'incite les médecins à être sensibles aux coûts des services qu'ils vous suggèrent. Ce sont eux qui contrôlent ces services, qui établissent le diagnostic et qui nous disent ce dont nous avons besoin. Rien ne les incite à limiter le nombre de tests en laboratoire ou de tests sanguins, ni à éviter de nous envoyer sans fin chez des spécialistes, quitte à revenir les voir ensuite.

J'ai étudié avec soin les systèmes de santé du Royaume-Uni, de la Nouvelle-Zélande, des Pays-Bas et des États-Unis. D'ailleurs, vous pouvez acheter mon livre pour vraiment pas cher. Je répondrai donc avec plaisir à toutes les questions que vous pourriez avoir au sujet de ces pays. Toutefois, dans le peu de temps qu'il me reste, je voudrais signaler les caractéristiques uniques du système canadien, puis faire quelques observations un peu plus dirigistes que ceux que j'ai l'habitude de faire, lesquelles

Medicare. I will comment on that, but I just want to first say what makes Canada unique.

Canada is unique because it has this very strong protection in the Canada Health Act of medically necessary hospital and physician services. That is unique. No other country does that. It prohibits extra billing and user charges for these medically necessary hospital and physician services.

Some countries, like New Zealand and the United States, have significant user charges to see a family doctor. I am from New Zealand. When I go to the family doctor, I have to shell out \$40. Most of the middle class and wealthy people have private insurance to cover that family doctor visit. Other countries, like the U.K., New Zealand, Australia, allow people to jump queues in the public sector by buying private insurance and buying care in the private sector. These countries allow their physicians to work in the public sector and top up their salaries by working in the private sector.

The kind of care that is provided in the private sector is basically easy care, that is, the "ectomies" — tonsillectomies, adenoidectomies, et cetera. It is not oncology it is not acute care.

Other countries, such as the Netherlands allow private insurance. However, it is important to realize that this is a very different kind of private insurance than the kind that advocates here are talking about. It is very different. In the Netherlands, they have to have compulsory coverage for catastrophic care. You might have noticed the big figure for the Netherlands, which is 11.5 per cent, when the averages are around 2 per cent and 3 per cent. That is because they provide all this long-term care for all their population compulsorily.

The richer 40 per cent of those in the Netherlands can buy regular kinds of care from private insurance — but private insurance cannot cherry-pick. They can not do just the "ectomies"; they have to do everything. It is not such a lucrative thing when you have to provide the whole range of care.

Because there is such a strong commitment to equity and what they call solidarity in the Netherlands, all hospitals treat the same those who have social insurance, that is, public coverage, and those who have private insurance. Physicians consider it unethical to allow people who have private insurance to jump queue. They do not have the kinds of laws that we have, the regulatory framework through the Canada Health Act, but they achieve it through other means — that is to say, through ethical norms, essentially. There is a very strong commitment to solidarity. Even though they have all this private insurance, it is necessary to look beyond that to see what actually happens in the country.

vous ont été distribuées en fait. Il s'agit d'un document que j'ai préparé exposant les différentes options de politique permettant de redresser le Medicare. J'y reviendrai, mais je voudrais d'abord expliquer en quoi le Canada est unique.

Le Canada est unique parce qu'il a maintenu farouchement dans la Loi canadienne sur la santé les services des médecins et les services d'hospitalisation requis du point de vue médical. C'est cela qui est unique en soi, et qu'aucun autre pays n'a fait. La loi interdit la surfacturation et les frais d'utilisation pour tous les services de médecins et d'hospitalisation requis du point de vue médical.

Dans certains pays, comme la Nouvelle-Zélande et les États-Unis, on impose des frais d'utilisation considérables pour la consultation du médecin de famille. Je suis moi-même originaire de la Nouvelle-Zélande, et chaque fois que je vais visiter mon médecin de famille, je dois cracher 40 \$. La plupart des citoyens de la classe moyenne et les gens aisés ont acheté des assurances privées qui assument la visite chez le médecin de famille. Dans d'autres pays, comme le Royaume-Uni, la Nouvelle-Zélande et l'Australie, on permet aux citoyens de contourner l'affluence du secteur public par l'achat d'assurances privées et l'achat de soins dispensés dans le privé. Ces pays permettent à leurs médecins de travailler dans le secteur public, mais d'arrondir leurs fins de mois en travaillant aussi dans le privé.

Le secteur privé s'occupe surtout des opérations de routine, c'est-à-dire des ablations — amygdales, végétations, et cetera. Il ne s'occupe pas d'oncologie ou de soins aigus.

D'autres pays, dont les Pays-Bas, permettent l'assurance privée. Il faut toutefois se rendre compte qu'il ne s'agit pas du tout du genre d'assurance privée qui est parfois préconisée au Canada. Aux Pays-Bas, la protection au titre des soins dans les cas graves est obligatoire. Vous avez peut-être remarqué qu'aux Pays-Bas, le chiffre est très élevé, soit 11,5 p. 100, alors que les moyennes tournent autour de 2 à 3 p. 100. Cela est dû au fait que toute la population est obligatoirement protégée au titre des soins à long terme.

Les 40 p. 100 des mieux nantis des Pays-Bas peuvent se procurer une assurance privée ordinaire — mais les assureurs privés ne peuvent pas être sélectifs. Ils ne peuvent pas limiter la protection seulement aux ablations; la protection doit être totale. Ce genre d'assurance n'est pas aussi lucratif lorsqu'il faut couvrir toute la gamme des soins.

Puisqu'il existe aux Pays-Bas un solide engagement en matière d'équité et de solidarité, les hôpitaux traitent de la même façon les patients protégés par l'assurance sociale, c'est-à-dire l'assurance publique, et ceux qui sont protégés par l'assurance privée. Les médecins estiment qu'il est contraire à l'éthique de permettre aux personnes protégées par une assurance privée d'avoir priorité. Les Hollandais n'ont pas de lois comme les nôtres, le cadre de réglementation en vertu de la Loi canadienne sur la santé, mais ils obtiennent les mêmes résultats par d'autres moyens — en gros, par des normes d'éthique. Ils attachent énormément d'importance à la solidarité. Même s'il existe de nombreux régimes d'assurance privée, il faut aller au-delà pour voir ce qui se fait vraiment dans le pays.

In Canada, because of this very rigid boundary set by the Canada Health Act between hospital and physician services, which are protected no matter how useless they are, and other kinds of health care services, there has been significant passive privatization. Technology has developed. With it, the locus of care has shifted from hospitals into homes. There has been movement toward more drug therapy. There is more reliance on medical equipment and care provided by other kinds of health care professionals, not just physicians. We have seen a great deal of passive privatization and these services and goods are not protected by the Canada Health Act. Thus, they fall into a sector of mixed and varied private and public financing, which varies from province to province.

This passive privatization process, together with fiscal constraints, is largely responsible for the shrinkage of the public share of total health care expenditure in Canada from 74.6 per cent in 1990 to 69.8 per cent in 1997. This figure of 69.8 per cent of public spending on health is significantly lower than New Zealand's figure of 77.3 per cent and the U.K.'s figure of 84.6 per cent. There is a big difference. However, it is about the same as in Australia but significantly higher than the U.S. figure of 43 per cent.

I wish now to make some more prescriptive comments, if I may, for reform of the Canadian system in light of what I know about these other health care systems. I think the way to go about this is to ask: What is our ultimate objective here? Is it the redistributive one of ensuring that everyone has access to a range of health care services on the basis of need and not ability to pay? If we can agree on that, that is a big start. If we can agree on that, then I think the principles that should guide reform are three. They are accountability, integration and flexibility.

We spend a great deal of money on health care. It absorbs 9.2 per cent of gross domestic product, which amounted to \$86 billion in 1999. If we were contemplating a successful company of this size, we would have astute managers managing that company. We would see them changing and moving and responding to the dynamics of the system. However, within the public health care system, managers do not have the same incentives to respond to changes and to evolve continually so as to improve performance. When I mention this comparison with the private sector, it is not to advocate privatization — not by any stretch — because the goal of the health care system is redistributive not efficiency. That does not mean that we should not try efficiently to achieve our redistributive objective. That seems to me to be the difference here.

We have to consider ways that we can ensure better decision making and better management of our publicly funded system. The best way to do this is to improve the accountability of decision makers.

Everyone acknowledges that throwing increasing amounts of money into the health care system is not sustainable in the absence of economic growth. Putting more and more into it means we spend less and less on other things, such as education, income

Au Canada, compte tenu des critères très rigides de la Loi canadienne sur la santé en matière de services hospitaliers et médicaux, aussi inutiles qu'ils soient, et en matière d'autres services de soins de santé, il s'est produit une privatisation passive importante. La technologie a évolué. Parallèlement, les soins ont été de moins en moins dispensés dans les hôpitaux et de plus en plus à domicile. On s'est de plus en plus orientés vers le traitement pharmaceutique. On compte davantage sur l'équipement et les soins médicaux fournis par d'autres types de professionnels de la santé, pas seulement par les médecins. Il y a eu une grande privatisation passive, et ces produits et services ne sont pas visés par la Loi canadienne sur la santé. Ils relèvent donc de divers régimes privés et publics de financement qui varient d'une province à l'autre.

Cette privatisation passive, conjuguée aux compressions financières, est l'une des principales causes de la diminution de la part assumée par le secteur public dans le total des dépenses en soins de santé au Canada. Cette part est passée de 74,6 p. 100 en 1990 à 69,8 p. 100 en 1997. Cette part est considérablement inférieure à celles de la Nouvelle-Zélande et du Royaume-Uni qui sont respectivement de 77,3 p. 100 et de 84,6 p. 100. Il y a une grande différence. Elle est toutefois comparable à la part de l'Australie, mais bien supérieure à celle des États-Unis, où elle est de 43 p. 100.

Permettez-moi maintenant de faire des observations dont il y aurait lieu de tenir compte en vue d'une réforme du régime canadien, compte tenu de ce que je connais des autres régimes de soins de santé. Il faut d'abord établir quel est l'objectif ultime. S'agit-il de redistribuer la richesse en veillant à ce que l'accès aux soins de santé se fonde sur le besoin et non sur la capacité de payer? Si nous pouvons nous entendre sur ce principe, c'est déjà un grand pas en avant. Si nous nous entendons sur ce principe, il y a donc trois éléments qui doivent régir la réforme: la reddition de comptes, l'intégration et la souplesse.

Nous dépensons des sommes importantes au titre des soins de santé. Nous y investissons 9,2 p. 100 du produit intérieur brut, soit 86 milliards de dollars en 1999. Dans une société prospère de cette ampleur, on trouverait de brillants gestionnaires. Ces gestionnaires s'adaptent à l'évolution de la dynamique du système. Mais dans le régime public de soins de santé, les gestionnaires ne sont pas encouragés de la même façon à réagir au changement et à s'adapter constamment pour améliorer le rendement. Si je fais la comparaison avec le secteur privé, ce n'est pas pour préconiser la privatisation — loin de là — puisque le but du régime de soins de santé n'est pas l'efficacité, mais la redistribution de la richesse. Cela ne veut pas dire pour autant qu'il ne faut pas essayer d'être efficace pour atteindre cet objectif. C'est ce qui fait pour moi la différence.

Nous devons examiner comment on peut améliorer les décisions et la gestion du régime que finance notre secteur public. La meilleure façon, c'est d'améliorer la reddition de comptes des décideurs.

Tous reconnaissent que sans croissance économique, il est inutile d'accroître le financement du régime de soins de santé. L'argent ainsi investi ne pourrait être dépensé ailleurs, par exemple dans l'enseignement, le soutien du revenu, la création

support, job development, et cetera. If more money is not the sustainable answer, then more accountability and better management must be. Although the phrase “managed care” has been tainted with the excesses and inequities of the U.S. system, I think the concept is still sound. It is to monitor doctors’ decisions to ensure that the most cost-effective service is selected to treat a particular health need. It is necessary to ensure that doctors have incentives to select the most cost-effective service for a particular health need and that they prioritize health needs, because, obviously, some health needs are more important than others.

To date, Canada’s approach has not been better management but, rather, to reduce the resources available to the health care system. Thus, there are fewer hospitals, fewer hospital beds, fewer nurses and less technology. The hope is that doctors faced with these limited resources will allocate resources appropriately. We need to do better than this. We can by improving accountability.

Improving accountability is vital, as all systems faced with the imperative to contain costs have strong tendencies to shift costs rather than to improve performance. In Canada, the U.K., New Zealand and in many other countries, cost shifting has manifested itself in long waiting times and long waiting lists and shifts to informal caregiving. Health policy analysts and economists — and I have fallen into this on occasion — have become unduly fixated on health outcomes. Unless we can measure it, it does not matter. As a result, we have dismissed concerns about waiting lists and informal caregiving unless it has a measurable impact on health outcomes. We have failed to take account of real people’s anxieties and concerns about growing waiting times and have discounted the burden of providing informal care, along with the personal and financial impact of that. We do not even measure the direct loss of salary or wages while waiting or providing informal care, given that this is not a cost that is absorbed by the health care budget. Ordinary people know that there are real costs for them, and health decision makers must be more responsive to the concerns of the people they represent, to ensure the long-term sustainability of the system. Without it, support for medicare has and will continue to wane, and there will be continued cause for more private financing, which undermines the larger redistributive objective.

Canada is unique in largely precluding a two-tier private insurance system, such as exists in the United Kingdom and New Zealand. That is an important accountability mechanism, as it includes everyone in the same system so that the middle class and the wealthy use their voice to advocate for maintaining the quality of the public system. I think that is an important point. In the U.K. and New Zealand, countries that have this supplementary private insurance system, which I reiterate again is quite different from what happens in the Netherlands, waiting lists are far, far longer. In fact, they are five times as long as a percentage of the population in New Zealand and three times as long in the U.K.

d’emplois, et cetera. Si la solution n’est pas d’accroître le financement, il faut donc se tourner vers une meilleure reddition de comptes et une meilleure gestion. Même si l’expression «soins gérés» porte la connotation des excès et des iniquités du régime américain, j’estime que le concept est encore valable. Il consiste à surveiller les décisions des médecins afin que soit choisi le service le plus rentable pour traiter un problème de santé particulier. Il faut voir à ce que les médecins soient encouragés à choisir le service le plus rentable pour chaque besoin en soins de santé et à établir la priorité de ces besoins puisque certains sont évidemment plus importants que d’autres.

Jusqu’à présent, le Canada n’a pas visé à améliorer la gestion mais plutôt à réduire les ressources dont dispose le régime de soins de santé. C’est ainsi qu’on a moins d’hôpitaux, moins de lits d’hôpitaux, moins d’infirmiers et d’infirmières et moins de technologies. On espère qu’en limitant les ressources, les médecins utiliseront mieux ce dont ils disposent. Il faut faire davantage et pour cela, il faut améliorer la reddition de comptes.

Il est essentiel d’améliorer la reddition de comptes puisque dans tous les systèmes où il est impératif de limiter les coûts, on a généralement tendance à réaffecter les coûts plutôt qu’à améliorer le rendement. Au Canada, au Royaume-Uni, en Nouvelle-Zélande et dans bon nombre d’autres pays, cette réaffectation des coûts a eu pour effet d’augmenter les temps d’attente, d’allonger les listes d’attente et de favoriser davantage les soins informels. Les analystes de la politique de la santé et les économistes — et je l’ai constaté à quelques reprises — ont malheureusement attaché trop d’importance aux résultats en matière de santé. Si cela ne peut pas être mesuré, cela n’a pas d’importance. Par conséquent, on n’a tenu compte du problème des listes d’attente et des soins informels que dans la mesure où il a des effets mesurables sur les résultats en matière de santé. On n’a pas tenu compte des craintes et des préoccupations de la population au sujet de l’allongement des délais d’attente non plus que du fardeau que constituent les soins informels, avec tous les effets qu’ils ont du point de vue personnel et financier. On ne mesure même pas la perte directe de salaire que représentent les délais d’attente et les soins informels, parce que ces coûts ne se retrouvent pas dans le budget des soins de santé. Mais le Canadien moyen sait que cela représente des coûts réels, et les décideurs du domaine de la santé doivent être plus sensibles aux préoccupations des gens qu’ils représentent afin de garantir la viabilité à long terme du régime. Sinon, l’appui à l’assurance-maladie continuera de faiblir et il y aura des motifs constants d’accroître le financement privé, ce qui mine l’objectif général de redistribution de la richesse.

Le Canada est puisqu’il interdit l’instauration d’un régime d’assurance privée à deux paliers, comme il en existe au Royaume-Uni et en Nouvelle-Zélande. C’est un mécanisme de reddition de comptes important, puisque toute la population est incluse dans le même régime et que de cette façon, la classe moyenne et les bien nantis défendent la qualité du régime public. C’est un élément important. Au Royaume-Uni et en Nouvelle-Zélande, où il existe ce régime d’assurance privé supplémentaire, qui, je le répète, est très différent de celui des Pays-Bas, les listes d’attente sont infiniment plus longues. En fait, en pourcentage de la population, elles sont cinq fois plus longues

Arguably, once there is that kind of private insurance, perhaps the middle class and wealthy lose their incentive to lobby for improvements in the public system.

Including everyone in the same system seems to me to be a good starting point. I think Canada does well in doing this, but I do not think it is enough alone.

Decision makers must be accountable both in the short and the long term for the consequences of their decisions. The Canadian system is characterized by fracturing of accountability amongst different levels of government, health authorities, hospitals, nurses, physicians and other providers. With all due respect, governments do not have much incentive to put in place mechanisms to make themselves more accountable, unfortunately. Perhaps the only way to negotiate this dead end is to devolve decision making to locally elected, or government-appointed, health authorities, and then concentrate on accountability measurements to ensure their performance.

I cannot obviously give you the whole blueprint here. If I could, I would be a millionaire.

However, some success has been met in other countries with performance agreements between governments and health authorities setting out government objectives in terms of health outcomes, waiting times, et cetera. They require ongoing evaluation and monitoring of these health authorities performance. Once these kinds of contracts or agreement between government and health authorities are in place, some improvement on those things that you are concerned about seems to take place.

We need more information in order to do this. We all know that. We also should think about other accountability-enhancing mechanisms. I talk about a few things like mandatory consultation and a health ombudsman or health care commissioner. I will not go into that too much.

The other important principle to guide reformers is integration. If there are incentives for health authorities to be good decision makers, then the authorities must be given the tools to make good decisions. They must have control over a budget for wide range of health care services. They must control the budget for the doctors and for drugs and for home care and for hospitals in order that they can make effective substitution decisions. We still have many silos of financing, which means that we often have very silly decisions made about who gets what kind of care.

The final principle that should guide reform is flexibility. The Canada Health Act is wonderful in terms of its core values, but it is a product of the 1950s and 1960s, when hospital and physician services were seen as the boundaries of the system. Technology has overtaken the Canada Health Act.

en Nouvelle-Zélande et trois fois au Royaume-Uni. C'est peut-être dû au fait que s'il existe un tel régime d'assurance privée, la classe moyenne et les bien nantis ne sont pas incités à exercer des pressions pour que le régime public soit amélioré.

C'est donc un bon point de départ que d'inclure toute la population dans le même régime. Le Canada a raison d'adopter ce principe, mais ce n'est pas suffisant.

Les décideurs doivent rendre des comptes à court terme et à long terme des conséquences de leurs décisions. Dans le régime canadien, la reddition de comptes est disséminée entre les divers ordres de gouvernement, les autorités en matière de santé, les hôpitaux, les infirmiers et infirmières, les médecins et autres dispensateurs de soins. À vrai dire, les gouvernements ne sont pas vraiment incités à adopter des mécanismes pour augmenter leur reddition de comptes, et c'est malheureux. Le seul moyen de sortir de cette impasse est peut-être de confier la tâche des décisions à des autorités en matière de santé élues localement ou nommées par le gouvernement et de concentrer les efforts sur l'évaluation de la reddition de comptes afin de vérifier leur rendement.

Je ne suis malheureusement pas en mesure de vous offrir un plan complet. Si je le pouvais, je serais millionnaire.

Mais dans d'autres pays, on a obtenu de bons résultats lorsque les gouvernements et les autorités en matière de santé ont conclu des ententes de rendement dans lesquelles étaient énoncés les objectifs du gouvernement en matière de résultats, de délais d'attente, et cetera. Le rendement de ces autorités en matière de santé doit être évalué et surveillé constamment. Une fois que sont conclus de tels contrats ou de tels accords entre le gouvernement et les autorités en matière de santé, il semble que certaines des améliorations qui vous préoccupent se réalisent.

Nous savons que nous avons besoin de plus d'information. Il faudrait également envisager d'autres mécanismes qui accroissent la reddition de comptes. Il y a entre autres la consultation obligatoire et la création d'un poste d'ombudsman de la santé ou de commissaire des soins de santé. Je ne vais pas entrer dans les détails.

L'autre grand principe d'une telle réforme est l'intégration. Lorsqu'on encourage les autorités en matière de santé à être de bons décideurs, il faut leur donner les outils dont elles ont besoin pour prendre de bonnes décisions. Elles doivent contrôler le budget d'une vaste gamme de services de soins de santé. Elles doivent gérer le budget consacré aux médecins, aux médicaments, aux soins à domicile et aux hôpitaux de façon à pouvoir prendre des décisions de rechange efficaces. Il existe encore de nombreux cloisonnements dans le financement, ce qui signifie qu'il se prend souvent des décisions stupides sur le genre de soins offerts et à qui ces soins sont offerts.

Le dernier principe qui devrait régir la réforme est la souplesse. La Loi canadienne sur la santé renferme d'excellentes valeurs de base, mais elle est le produit des années 50 et 60, une époque où les services des hôpitaux et des médecins étaient considérés comme tout ce que le régime pouvait offrir. La technologie a évolué plus rapidement que la loi.

We need to think about the process by which we decide which services are publicly funded and on what terms. We need to have a better decision-making process to decide what is in and what is out, and it must be flexible because this will change over time. It must be ongoing, so there are some home care services that should be publicly funded, some physician services that should not. Some hospital services should be publicly funded, and some should not. Sometimes, we should have user charges; sometimes, we should not. However, we must have a process to decide that on an ongoing basis.

Those countries that try to set in stone structural reforms invariably lurch from one reform to another, which is also set in stone. We have seen this around the country with different types of reform, but you see it particularly in other countries. In the U.K., a health economist there calls this the “periodic re-disorganization of health care systems.” If you try to set something in stone, it will not be flexible enough to respond to the underlying dynamic changes in technology and changes in demographics. There will be problems. Things may be fixed for a year or so, but there will be another big problem in five years time.

There must be flexibility in the system. In my opinion, the flexibility must come on the supply side. If the health authorities have good incentives, or if the departments have good incentives to make good decisions, there will be a lot more flexibility about what happens on the supply side, whether they want to contract for profit hospitals or not-for-profit hospitals, or home care providers, whoever. Provided they would have the right incentives to do the right job and we have a commitment to eke quality and solidarity through public financing, we should be much more open to flexibility and how we actually configure the supply side.

I think it is time to reform the Canada Health Act — although Monique Bégin would not want me to say that — to expand its boundaries, without losing its commitment to solidarity and equity. The principles of accountability, integration and flexibility must be incorporated into the Canada Health Act. We need to ensure that the values that underpin medicare, very important values, are sustained, but not necessarily in its present structure.

The Chairman: I thank the three of you for a very fascinating overview. When the committee studies these countries in detail, we will be having you back again.

I will ask the three of you a question.

As I listen to the three of you, and I read some of your testimony before, it seems to me that you are all advocating three principles. I will use different language than Professor Flood used, but it seems to me that your three principles are the following.

First, treat the health care system as a whole. We use the term “health care system” when we speak of it in politics. However, the reality is that medicare is covering less and less of the health care system because more and more is being done outside hospitals

Il faut trouver une façon de décider quels services seront financés publiquement et à quelles conditions. Il nous faut un meilleur processus de décision pour décider ce qui est financé et ce qu'il ne l'est pas, et ce processus doit être souple car il est appelé à évoluer. L'évaluation doit être constante, car certains soins à domicile devraient être financés par le secteur public alors que certains services par les médecins ne devraient pas l'être. Certains services offerts dans les hôpitaux devraient être financés par le secteur public, d'autres pas. Dans certains cas, il faudrait imposer un ticket modérateur, dans d'autres pas. Il faut toutefois qu'il y ait un processus pour en décider de façon constante.

Les pays qui essaient d'effectuer des réformes structurelles rigides finissent invariablement par passer d'une réforme à l'autre, toute aussi rigide. Nous l'avons constaté un peu partout au Canada, dans différents types de réforme, mais surtout dans d'autres pays. Au Royaume-Uni, un économiste de la santé appelle ce phénomène la désorganisation périodique du régime de soins de santé. Si vous essayez de créer un régime rigide, il ne vous sera pas possible de vous adapter à l'évolution de la technologie et de la démographie. Cela provoquera des problèmes. Un régime rigide peut fonctionner pendant un an, peut-être, mais il y aura d'autres grands problèmes au bout de cinq ans.

Le régime doit être souple. À mon avis, cette souplesse doit se trouver du côté de l'offre. Si l'on offre suffisamment d'incitatifs aux autorités en matière de santé, ou si les services sont encouragés à prendre de bonnes décisions, il y aura davantage de souplesse du côté de l'offre, qu'il s'agisse de contrats avec des hôpitaux à but lucratif ou à but non lucratif, ou de contrats avec des gens qui dispensent des soins à domicile, et cetera. Avec suffisamment d'incitatifs pour faire ce qu'il faut et si nous nous engageons à assurer la qualité et la solidarité par le biais du financement public, nous devrions envisager une souplesse plus grande et voir comment nous pouvons configurer l'offre.

Le temps est venu de réformer la Loi canadienne sur la santé — même si Monique Bégin ne voudrait pas que je dise qu'il faut en accroître la portée — sans pour autant perdre cet engagement d'assurer la solidarité et l'équité. Il faut intégrer à la loi les principes de la reddition de comptes, de l'intégration et de la souplesse. Nous devons garantir que les valeurs sur lesquelles se fonde l'assurance-maladie, des valeurs très importantes, sont maintenues, même si ce n'est pas nécessairement dans leur structure actuelle.

Le président: Je vous remercie tous les trois de ce fascinant survol. Nous vous entendrons de nouveau lorsque le comité étudiera en détail ces pays.

J'ai une question à vous poser à tous les trois.

Je vous ai écoutés et j'ai lu certains de vos témoignages antérieurs, et il me semble que tous les trois, vous préconisez trois principes. Je vais utiliser des termes différents de Mme Flood, mais il me semble que ces principes sont les suivants.

Premièrement, il faut traiter le régime de soins de santé dans son ensemble. En politique, nous parlons du régime de soins de santé. Toutefois, dans les faits, l'assurance-maladie représente une part de moins en moins grande du régime de soins de santé

anyway. Professor Stabile talked about glasses not being covered but the eye doctor is, and so on. That is a good example.

Your second principle is that we need to put in place incentives for the primary care people, GPs, to use services efficiently, in a systemic sense, and to deal with specialists and what they recommend in drugs. Some of you put it in different ways. Professor Flood talked about monitoring doctors' decisions. Professor Blomqvist talked about some of the examples elsewhere. He talked in particular about capitation or the gate-keeping system, both of which have built in incentives. The principal, it seems to me, is that you want incentives for the primary care physician to think of the system cost as a whole, not merely his costs.

The third principle, which I guess was more clearly put by Professor Blomqvist in some of his examples, was that competition among providers beyond the primary gatekeeper may in fact be a good thing. He talked about fund holding. A number of you talked about regional health authorities, which may be competition under some equivalent kinds of name.

Am I correct that the basic argument that all three of you would make, although based on different countries and using different words, would be those three principles? If I am not, help to tell me where I am right or wrong.

Second, has anyone done a document or report that would address, for instance, my second principle, to provide doctors and primary care givers with the incentive to use the system efficiently? Is there a compendium somewhere of all the incentives that have been used in the world on that one point, or is there a compendium that deals with how you can get an element of competition among providers through the voucher system, fund holding or a variety of idea?

Professor Flood, I would ask you to begin. Are my principles basically the points that the three of you were trying to make?

Ms Flood: Yes. I would comment about the third one, regarding competition on the supply side. I am advocating that you have to think about incentives for the actual insurers, or the buyers of care — the decision makers. They can be fund holders. They can be health authorities. It is whoever holds the money.

The Chairman: Returning to Professor Blomqvist's initial model, you think that, rather than necessarily driving the incentives to the suppliers, you would drive them to the individuals who provide the money to the suppliers.

Ms Flood: Yes.

The Chairman: It would not matter whether that is a government or HMO, et cetera.

puisque les soins sont de plus en plus offerts à l'extérieur des hôpitaux. M. Stabile a dit que l'assurance-maladie ne remboursait pas les lunettes, mais qu'elle payait les honoraires de l'ophtalmologiste. C'est un bon exemple.

Votre deuxième principe, c'est qu'il faut offrir des incitatifs aux soignants primaires, les médecins de famille ou généralistes, afin qu'ils utilisent de façon efficace les services, de façon systémique, dans le renvoi aux spécialistes et les médicaments qui sont recommandés. Certains d'entre vous l'ont exprimé différemment. Mme Flood a parlé de surveillance des médecins et des décisions. M. Blomqvist a mentionné des exemples d'autres pays. Il a parlé plus particulièrement de capitation ou d'un régime de surveillance, qui tous les deux contiennent des incitatifs. L'essentiel, il me semble, est que vous souhaitez des incitatifs pour les médecins de soins primaires afin qu'ils tiennent compte des coûts pour tout le système et non seulement de leurs coûts à eux.

Le troisième principe, qui a été plus clairement énoncé par M. Blomqvist dans certains de ses exemples, est que la concurrence entre les professionnels de la santé, au-delà des soins primaires, est en fait une bonne chose. Il a parlé d'organismes de financement. Certains d'entre vous ont parlé d'administrations régionales de soins de santé, qui peuvent représenter une concurrence sous divers noms.

Ai-je raison de croire que ce que vous préconisez tous les trois, même si c'est selon des termes différents et en fonction de pays différents, ce sont ces trois principes? Sinon, aidez-moi à comprendre où je me trompe.

Deuxièmement, l'un d'entre vous a-t-il préparé un document ou un rapport sur mon deuxième principe, soit celui qui consiste à inciter les médecins et les soignants primaires à utiliser le régime efficacement? Existe-t-il quelque part une liste de tous les incitatifs qui ont été utilisés au monde à un moment donné ou un document qui montre comment on peut susciter la concurrence entre soignants grâce à un régime de ticket modérateur, ou par d'autres moyens?

Madame Flood, je vous demanderais de répondre la première. Ces principes correspondent-ils aux arguments que vous avez présentés?

Mme Flood: Oui. Permettez-moi de faire une observation au sujet du troisième, c'est-à-dire de la concurrence du côté de l'offre. Ce que je préconise, ce sont des incitatifs pour les fournisseurs d'assurance ou les acheteurs de soins — c'est-à-dire les décideurs. Il peut s'agir des organismes de financement ou des administrations de soins de santé. Il s'agit de ceux qui ont l'argent.

Le président: Pour revenir au modèle initial de M. Blomqvist, vous croyez qu'au lieu d'offrir nécessairement les incitatifs aux fournisseurs, il faudrait les offrir à ceux qui fournissent l'argent aux fournisseurs.

Mme Flood: Oui.

Le président: Peu importe qu'il s'agisse d'un gouvernement, d'une OSIS ou d'un autre organisme?

Ms Flood: Yes. On the supply side, there are many different health care markets. They do not all look the same. For some markets, there is just never going to be competition — for example, psychiatric service. For other markets, long-term care, for example, there is much opportunity for competition between providers.

You must have a smart decision maker, a smart buyer, who will decide over time whether to provide the services themselves, whether to own the hospitals themselves, whether to contract out to competing hospitals and home care providers. That is the nub of it.

Ms Flood: Therefore, in the U.K., they have decided that the budgets cannot really be wrestled away from the doctors, that it is better to give the budgets to the doctors themselves. Now, community nurses have large primary care groups and they bundle them altogether. They will decide how to buy the care from hospitals, the home care and the drug budget, et cetera, and they will manage it. Other countries have used government-appointed or elected health authorities to try to do this. None of these countries, apart perhaps from the fund holders, has thought very hard about how to actually make good decisions. If good decisions are not made, then it is a waste of time.

Mr. Blomqvist: I think that there is a hierarchy amongst your principles, Senator Kirby. I very much agree with the concept of integration — what Professor Flood calls integration. There has to be a single controller of the overall budget. That controller actually, effectively, makes the decisions for the patient on the mix of inputs — the hospital services, pharmaceuticals, physician services and so forth. That can be a capitated GP who is a fund holder, but it can also be an insurance plan that competes with other insurance plans. As long as there is integration in that sense, it can also be a district health authority who purchases care on behalf of its insured population. Integration is one element; and the other, in the United Kingdom, is the purchaser/provider split that was part of their reforms, in addition to the fund holding business.

Another element is competition, which is necessary either in order to ensure price competitiveness or to make sure that quality is maintained. If there are controlled prices, for example through capitation, then the only way to ensure that the fund holding GPs will, in fact, provide adequate care, is by leaving the patient the option of going to some other GP if they are not satisfied.

The competition can be between competing insurance plans, if you want to allow that. However, there must be some kind of competition amongst these integrated agents. The

Mme Flood: Oui. Il existe différents marchés des soins de santé du côté de l'offre. Ils ne sont pas toujours semblables. Dans certains marchés, il n'y aura jamais de concurrence — par exemple dans le cas des services psychiatriques. Dans d'autres marchés, les soins à long terme, par exemple, il est davantage possible de susciter une concurrence entre les fournisseurs de services.

Ce qu'il faut, ce sont des décideurs et des acheteurs intelligents qui décideront s'il vaut mieux qu'ils offrent les services eux-mêmes, qu'ils possèdent eux-mêmes les hôpitaux, ou s'il vaut mieux offrir les services à contrat par le truchement d'hôpitaux concurrents et de fournisseurs de soins à domicile. Voilà l'essentiel.

Mme Flood: Par conséquent, au Royaume-Uni, on a décidé que les budgets ne pouvaient pas être vraiment enlevés aux médecins, qu'il était préférable de confier ces budgets aux médecins eux-mêmes. Les infirmières en santé communautaire dispensent des soins primaires à un très grand nombre de personnes et elles les regroupent. Ce sont elles qui décident des modalités d'achat de soins dans des hôpitaux, de soins à domicile, du budget pour les médicaments, et cetera, et ce sont elles qui administrent le tout. Dans d'autres pays, le gouvernement nomme des administrateurs à cette fin, ou encore les membres des administrations des soins de santé sont élus. Dans aucun de ces pays, personne n'a vraiment bien réfléchi à la façon dont il faut prendre de bonnes décisions, sauf peut-être ceux qui détiennent les fonds. Si l'on ne prend pas de bonnes décisions, on perd son temps.

M. Blomqvist: Je pense qu'il y a un certain ordre hiérarchique dans vos principes, sénateur Kirby. Je suis tout à fait d'accord en ce qui concerne le concept de l'intégration — ce que Mme Flood appelle intégration. Il faut un contrôleur unique pour l'ensemble du budget. Ce contrôleur prend effectivement les décisions pour le patient, au sujet d'une variété de services — les services hospitaliers, pharmaceutiques, médicaux et ainsi de suite. Il peut s'agir d'un généraliste qui a un contrat de paiements par capitation et qui détient une enveloppe budgétaire, mais il peut s'agir également d'un régime d'assurance qui est en concurrence avec d'autres régimes d'assurance. À condition qu'il y ait intégration dans ce sens, il peut s'agir également d'une administration de soins de santé de district qui achète des soins au nom de la population qu'elle assure. L'intégration est un élément; et au Royaume-Uni, l'autre élément est la séparation entre l'acheteur et le fournisseur de services, qui faisait partie des réformes en plus de l'aspect détenteur de fonds.

Il y a un autre élément et c'est la concurrence, qui est nécessaire pour assurer la compétitivité quant aux prix ou encore le maintien de la qualité. Si les prix sont contrôlés, par exemple au moyen d'une formule de paiement par capitation, la seule façon de s'assurer que les généralistes détenteurs des fonds dispenseront effectivement des soins appropriés, consiste alors à laisser aux patients le choix de s'adresser à un autre médecin s'ils ne sont pas satisfaits.

Il peut y avoir concurrence entre des régimes d'assurance, si vous voulez le permettre. Cependant, il faut une forme de concurrence entre ces agents intégrés. La séparation entre

purchaser/provider split does not allow that and does not provide that, except that there is political accountability in those systems.

Ms Flood: Right.

Mr. Stabile: I think that all three incentives for GPs are comprehensive. Regarding the incentives for GPs, it is important that we think they are the right idea in some cases and the wrong idea in other cases. There are incentives that can be applied in many areas. Those include the supply-side incentives, such as doctors and insurers. Also, in some cases, they can insure the actual patients themselves. There is room for incentives to be placed on everybody in the system.

Another area is the competition among providers. Competition in the U.S. allows the flexibility that Professor Flood was talking about. In HMOs, they change all the time; when something does not work, they change it. When drugs become part of something, they change it because they have the flexibility to do that. We have been running a system that is a good one but, it does not have as much flexibility. It is important that there be flexibility in the system.

Senator Fairbairn: Have any of you been following the situation in Alberta regarding the health act?

Ms Flood: Yes.

Senator Fairbairn: Having listened to your remarks, can you relate that to some of your remarks? Of course, you are aware that there has been a lively and vigorous debate, which is probably far from over. I guess ask the question because, perhaps, you are telling us that the health act, which is wonderful, also is a product of almost a by-gone era and that there is a necessity to change it, not destroy it.

Obviously, change comes with difficulty and I am wondering how you would relate the Alberta experience. Is it something that you see as compatible with our health care system as we know it, or, as some of the top concerns of people in the province will indicate, do you see that it will not reduce costs and waiting lists? Will it lead to enhanced services and health care? It is an issue that is happening in Alberta, but it certainly reaches out to concerns all across the country.

Ms Flood: I have looked at Bill 11. When I first heard about Premier Klein's proposals, people that I know were agitated about it, and I thought they were being ridiculous. I thought that they were being too ideological; I did not see a problem with contracting out to competing hospitals — private or not-for-profit. However, I had it eat my words when I went to look at Bill 11, because, as you may have picked up, my big concern is to ensure that equity is achieved through public financing. I would like it expand public financing to drugs and home care and other things. I am much more open to flexibility on the supply side. In looking at Bill 11, the definition of enhanced health care services includes the kinds of services that are meant to be covered under Canada Health Act and are meant to be publicly funded.

l'acheteur et le fournisseur de services ne permet pas cela et ne le prévoit pas, sauf si ces systèmes comportent une obligation de rendre compte au niveau politique.

Mme Flood: En effet.

M. Stabile: Je pense que les trois incitatifs offerts aux généralistes couvrent tout. En ce qui concerne ces incitatifs, il est important de penser que c'est une bonne idée dans certains cas et une mauvaise idée dans d'autres cas. Il y a des incitatifs qui peuvent être appliqués dans bien des secteurs. Il y a par exemple les incitatifs axés sur l'offre, c'est-à-dire sur les médecins et les assureurs. Dans certains cas, ils peuvent même assurer eux-mêmes leurs propres patients. Il est possible d'offrir des incitatifs à tous les intervenants dans le système.

Il y a un autre élément qui est la concurrence entre les fournisseurs de services. Aux États-Unis, la concurrence permet la flexibilité dont Mme Flood parlait. Dans les organisations de soins intégrés de santé, on apporte constamment des changements; lorsqu'une chose ne fonctionne pas, on la change. Lorsqu'il y a de nouveaux médicaments, on peut apporter le changement nécessaire parce qu'il y a suffisamment de flexibilité dans le système. Nous avons un système qui est bon, mais il ne comporte pas autant de flexibilité. Il est important que le système comporte une certaine flexibilité.

Le sénateur Fairbairn: Avez-vous suivi l'évolution de la situation en Alberta, en ce qui concerne la Loi sur la santé?

Mme Flood: Oui.

Le sénateur Fairbairn: Pouvez-vous faire un lien entre cette situation et certaines de vos remarques? Vous savez certainement que le sujet a suscité un débat très animé qui est probablement loin d'être terminé. Je vous pose la question parce que vous nous dites que la Loi sur la santé, qui est merveilleuse, est aussi un produit d'une époque presque révolue et qu'il est nécessaire de la modifier, et non pas de la détruire.

Évidemment, il est difficile de faire accepter des changements et je demande comment vous voyez l'expérience de l'Alberta. Pensez-vous qu'elle est compatible avec notre système de soins de santé tel que nous le connaissons, ou pensez-vous comme certains dans la province qui craignent que cette mesure ne réduise pas les coûts et ne fasse pas diminuer les listes d'attente? Verra-t-on une amélioration des services de santé? C'est une chose qui se passe en Alberta, mais elle inquiète certainement des gens dans toutes les régions du pays.

Mme Flood: J'ai regardé le projet de loi 11. Lorsque j'ai entendu parler pour la première fois des propositions du premier ministre Klein, des personnes de ma connaissance sont devenues très agitées et je pensais qu'elles étaient ridicules. Je pensais qu'elles s'attachaient trop à leur idéologie; je ne voyais pas de problème dans la passation de marché de services avec des hôpitaux concurrents — privés ou à but non lucratif. J'ai cependant été obligés de ravalier mes paroles lorsque j'ai jeté un coup d'oeil au projet de loi 11, car ma grande préoccupation, comme vous l'avez peut-être compris, est que le financement public assure l'équité pour tous. Je voudrais que le financement public s'étende aux médicaments, ainsi qu'aux soins à domicile et à d'autres services. Je suis beaucoup plus en faveur de la

Thus, if a physician says that the MRI service is not medically necessary for a patient, he may actually be saying that the patient is being over anxious. The doctor determines what is medically necessary for the patient. The doctor may say to a patient who is not covered under a publicly funded system that if the patient wants to step down the hallway to the private medical office, the service can be provided privately — fee-for-service basis — and quickly. Once I saw that, and I realized that this was allowing two-tier private financing for enhanced health care services, I had to eat my words and e-mail everyone to tell them that they were right. In respect of the actual concept of contracting out to competing not-for-profit and for-profit providers, I am not ideologically opposed to for-profit providers. If the “cat can be skinned” more efficiently that way and if there is a possibility of doing it then I am in favour of it. If it means opening it to private financing, which seems to be what Premier Klein is allowing through his definition of enhanced health care services, I think that is wrong and it really is contrary to the values that underpin the Canada Health Act.

Mr. Blomqvist: I have not looked at the actual legislation but I would like to add that the notion of actually reducing waiting lists by making contracts with private providers is something that some of the county councils in Sweden did a number of years ago. There has not been, to my knowledge, any criticism in Sweden to the effect that this was incompatible with the core values of the Swedish health care system. It did reduce waiting lists very expeditiously.

Ms Flood: People do not understand, often, the distinction between financing and delivery. Public financing is key; we have always had private delivery. Now we are just debating whether not-for-profit or for-profit is so evil.

Senator Fairbairn: You make a good point about what the public understands and what it does not. You indicated that we need to consider other accountability-enhancing mechanisms directly linking decision makers to the citizens that they represent, and mandatory consultation by health authorities with community that they represent. You also suggested that physicians will always have some level of discretion about what service to provide and to whom. There is a need for continuing public input into what should be the basket of services that are publicly funded.

How, in your mind, do you see that kind of public input and mandatory responsibility of health authorities to check in with communities? When we are talking of change, this is a critical element because, undoubtedly, many people rely on the opinion of

flexibilité du côté de l'offre. Dans le projet de loi 11, la définition des services de soins de santé améliorés comprend des types de services qui sont censés être assurés en vertu de la Loi canadienne sur la santé et qui doivent donc être financés par l'État.

Par exemple, si un médecin dit qu'un service d'imagerie par résonance magnétique n'est pas médicalement nécessaire pour un patient, il peut être en train de lui dire qu'il est trop inquiet. C'est le médecin qui détermine ce qui est médicalement nécessaire pour son patient. Le médecin peut dire à un patient qui n'est pas assuré par un régime public que s'il veut aller dans un cabinet médical privé juste à côté, le service pourra lui être fourni rapidement, contre paiement. Quand j'ai vu cela, je me suis rendu compte que cette mesure permettait un financement privé pour des services de santé améliorés, j'ai dû ravalé mes paroles et j'ai envoyé un message électronique à tous pour leur dire qu'ils avaient raison. Pour ce qui est de la notion même de la passation de marchés avec des fournisseurs concurrents à but non lucratif et à but lucratif, je ne suis pas opposée en principe aux fournisseurs à but lucratif. Il y a plusieurs façons de plumer un canard et s'il est possible de le faire ainsi plus efficacement, je suis tout à fait pour. Si cela signifie qu'il faut ouvrir la porte au financement dans le secteur privé, ce que le premier ministre Klein semble permettre, étant donné sa définition des services de soins de santé améliorés, je pense que c'est mal et vraiment contraire aux valeurs qui sous-tendent la Loi canadienne sur la santé.

M. Blomqvist: Je n'ai pas vu le texte du projet de loi, mais j'aimerais ajouter qu'il y a un certain nombre d'années, certains des conseils de comté en Suède ont passé des marchés avec des fournisseurs privés afin de faire diminuer les listes d'attente. Pour autant que je sache, on ne s'est pas plaint en Suède que cette mesure était incompatible avec les valeurs fondamentales du système de soins de santé de la Suède. La mesure a permis de diminuer les listes d'attente très rapidement.

Mme Flood: Souvent, les gens ne saisissent pas la distinction entre le financement et la prestation des services. Le financement par l'État est essentiel; nous avons cependant toujours eu des services dispensés par le secteur privé. Nous sommes en train de discuter pour déterminer si c'est vraiment mal d'avoir recours à des organismes à but non lucratif ou à but lucratif.

Le sénateur Fairbairn: Vous avez raison, quand vous parlez de ce que la population comprend et de ce qu'elle ne comprend pas. Vous avez dit que nous devons envisager d'autres mécanismes pour améliorer la reddition de comptes afin d'établir un lien entre les décideurs et les citoyens qu'ils représentent, et vous avez dit que les administrateurs des services de santé doivent consulter les collectivités qu'ils représentent. Vous avez également dit que les médecins auront toujours un certain pouvoir discrétionnaire quant aux services à fournir et à qui les fournir. Il faut consulter régulièrement la population au sujet des différents services qui doivent être financés par l'État.

Selon vous, comment doit se faire cette participation du public et cette consultation obligatoire des collectivités par les administrateurs du secteur de la santé? Lorsque nous parlons de changement, c'est un élément essentiel parce que beaucoup de

their doctors, or others in the system, and may not understand when we get into change and what that may involve.

Ms Flood: That is true, but it is absolutely key to take the public along with it.

Senator Fairbairn: How do you do that?

Ms Flood: There are many ways of doing it. Professor Blomqvist was talking earlier about competition between HMOs. I call that exit. You can take your voucher and shift it to another one. That is a mechanism of accountability, where I can move from a GP fund holder to another GP fund or I can take my government voucher from one health authority to the other one because I do not like the way they do their business. I call that exit. That is one mechanism of accountability, but I do not think it will ever fly here.

The other mechanism of accountability is what I call "voice," which is basically what I am talking about here. Voice is whereby people, health authorities, government authorities, and government decision makers are more responsive to the people they are meant to represent. Let us look at how other countries have engaged in reform.

In New Zealand, which I am most familiar with, the health authorities were required, through the agreements they negotiated with governments, to engage every year in mandatory consultation. They had to go out into the community and have things such as focus groups to discuss what the health care priorities should be in any particular year, where the needs were, and so on, from year to year. This has proved to be very effective. They also have what they call a core health services commission that travels around the country discussing with people what should be publicly funded and what should be in or out. They have given up trying to provide a definitive list, but they at least come up with what they think should be priorities that they inform the government about. The government then negotiates that with health authorities. This helps them. They say, "This year we will focus more on aboriginal health or on infant mortality. These have to be the priority areas this year to which we will direct more spending."

A number of countries have a health care commission or a health care ombudsperson. If a person has a complaint with a physician or a health authority, that person does not need to come running to a lawyer like me. The ombudsperson is there to help deal with concerns and complaints — for example, is someone is worried about where they are on a waiting list, or worried about this, that or the other thing. However, that is messy. Exit is nice and clean. It is this nice market thing, but it is actually very complicated. Voice, political accountability is messier, harder to do, but ultimately probably more appropriate for Canada.

Mr. Blomqvist: Something that I have always thought is an undersupplied area where the federal authorities in every country can be extremely helpful has to do with systematic technology

gens dépendent certainement de l'opinion de leur médecin et d'autres intervenants dans le système, et ils ne comprennent peut-être pas ce qui va se passer, lorsqu'intervient un changement.

Mme Flood: C'est exact, mais il est absolument essentiel d'amener le public à participer.

Le sénateur Fairbairn: Comment peut-on le faire?

Mme Flood: Il y a bien des façons de procéder. M. Blomqvist parlait tout à l'heure de la concurrence entre les organisations de soins intégrés de santé. J'appelle cela la sortie. Un patient peut prendre son billet de référence et aller ailleurs. C'est un mécanisme de reddition de comptes, qui permet de passer d'un généraliste détenteur d'une enveloppe budgétaire à un autre, ou encore un patient peut prendre son billet du gouvernement pour passer d'une administration de soins de santé à une autre, parce qu'il n'est pas satisfait. J'appelle cela la sortie. C'est un mécanisme de reddition de comptes, mais je ne pense pas que cela puisse jamais être accepté ici.

L'autre mécanisme de reddition de comptes est, pour l'essentiel, ce dont je vous parle et que j'appelle «la voix». C'est un système qui oblige les autorités sanitaires, les autorités publiques et les décideurs gouvernementaux à véritablement rendre des comptes à ceux qu'ils sont censés représenter. Examinons comment d'autres pays ont procédé pour aboutir à une réforme.

En Nouvelle-Zélande, situation que je connais le plus, les ententes négociées avec les gouvernements par les autorités sanitaires comportaient une clause de consultation obligatoire tous les ans. Elles avaient l'obligation de consulter les représentants des collectivités pour fixer les priorités, définir les besoins, d'une année sur l'autre. Cette procédure s'est avérée très efficace. Il existe également une commission de santé publique qui se déplace pour consulter directement la population sur les prestations devant être ou non publiquement financées. Ils ont renoncé à établir une liste définitive, mais ils peuvent au moins dresser une liste de priorités qu'ils communiquent au gouvernement. Le gouvernement négocie alors avec les autorités sanitaires. Cela les aide. Le gouvernement décide que cette année, par exemple, il donnera la priorité aux problèmes de santé autochtones ou de mortalité infantile. Ce seront cette année les domaines de financement public prioritaires.

Un certain nombre de pays ont une commission de soins de santé ou un médiateur chargé de ce dossier. Si vous avez à vous plaindre d'un médecin ou d'une administration sanitaire, vous n'avez pas à faire appel à un avocat spécialisé comme moi. Le médiateur est là pour entendre les plaintes comme par exemple si quelqu'un s'inquiète de sa place sur une liste d'attente ou s'inquiète d'une chose ou d'une autre. Il reste que c'est un peu compliqué. Le système que j'appelle «la sortie» semble plus simple. C'est une simple affaire d'offre et de demande mais en réalité, c'est très compliqué. Le système que j'appelle «la voix», le contrôle politique, est plus compliqué, plus lourd mais en fin de compte, probablement plus approprié pour le Canada.

M. Blomqvist: Il y a un domaine que j'ai toujours considéré comme sous-équipé dans lequel les autorités fédérales de chaque pays peuvent jouer un rôle extrêmement utile, et c'est celui de

evaluation. This is not just evaluating potential expensive new technologies, but it is also deciding what should be included: what are the costs of different kinds of interventions, even relatively mundane ones; what are the benefits; what is the scientific consensus with respect to that? Those issues, it seems to me, could go a long way towards creating some degree of consensus and acceptance of these principles.

Mr. Stabile: We are starting this in Canada. We are beginning to realize that there are differences in the way people use technologies across the country in general. There are some recent reports that have shown that we use technologies in very different ways in Ontario versus British Columbia versus other provinces, so there is not consensus — never mind among the patients — even among the medical community. As we move towards that, I hope this information will help the process along, and CIHI is starting this.

Senator Carstairs: I have a couple of general and then a couple of specific questions. It seems to me, when I look at studies comparing Canada with the Netherlands, the United Kingdom and Japan, I am struck with the fact that we have very different geographies. Have there been any studies done that evaluate the amount of money we spend per capita in Canada and its relationship to our geography?

Mr. Blomqvist: I think there have been some studies in places like Sweden where you have similar inequalities between the cost of health care in major urban centres and in remote rural areas. I am not particularly familiar with those, but I know that the levels of health care cost per capita at comparable standards are very different because of all the county councils, and some are very large and thinly populated while others are urban.

I guess I should stop there because I do not know anything specific.

Ms Flood: I do not know either. It is a good question: To what extent is geography a problem? A number of countries have this problem of dense urban centres and then hardly anyone out in the boonies. New Zealand and Australia have these problems. The problem is getting physicians out there. It is a real problem when you are paying them on a fee-for-service basis and they can all cluster in the urban areas and do not actually need to go out. If you pay them on a capitation basis, they will be out there.

Senator Carstairs: Of course. That is the whole point. I come from a province, Manitoba, in which we have one very large city, and then we have Brandon, and then nothing else really in terms of any significant grouping of people. Everyone has to be flown, in an emergency situation, into Winnipeg. That has to add to our costs considerably in comparison to the Netherlands, where, quite frankly, you can take an ambulance ride almost anywhere in the country.

Mr. Stabile: There are studies that compare, in particular, Manitoba to some of the U.S. states that have similar population

l'évaluation technologique systématique. Il ne s'agit pas simplement d'évaluer le coût potentiel des nouvelles technologies mais aussi de réfléchir à ce qui devrait être inclus: quels sont les coûts des différents genres d'interventions, même celles qui peuvent paraître relativement banales? Quels sont les avantages? Quel est le consensus scientifique sur la question? Il me semble que ces questions permettraient d'aboutir à un certain degré de consensus et d'acceptation de ces principes.

M. Stabile: Ça commence au Canada. Nous commençons à comprendre qu'il y a des différences d'utilisation des technologies d'un bout à l'autre du pays. Des rapports récents montrent que nous utilisons les technologies de manière très différente en Ontario par rapport à la Colombie-Britannique et par rapport à d'autres provinces. Il n'y a donc pas de consensus — certainement pas entre les patients mais encore moins dans la communauté médicale. J'espère que ce genre d'information nous permettra de faire avancer ce dossier que l'Institut canadien sur la santé commence à piloter.

Le sénateur Carstairs: J'ai une ou deux questions d'ordre général à vous poser et ensuite une ou deux questions d'ordre plus particulier. Quand j'examine les études comparatives entre le Canada, les Pays-Bas, le Royaume-Uni et le Japon, je suis frappée par le fait que nous avons des géographies très différentes. A-t-on jamais étudié ce que nous dépensons par habitant au Canada en quantifiant le facteur géographique?

M. Blomqvist: Je crois que des études de ce genre ont été faites en Suède où il y a des inégalités analogues entre les coûts de santé dans les gros centres urbains et les régions rurales éloignées. Je n'en connais pas particulièrement les résultats, mais je sais que les niveaux de coûts de santé par habitant à des normes comparables sont très différents à cause de l'existence de tous ces conseils de comté dont certains sont très importants et faiblement peuplés alors que d'autres sont urbains.

Mais je n'en dirai pas plus car je n'en sais pas assez.

Mme Flood: Moi non plus. C'est une excellente question: dans quelle mesure la géographie est un problème? Un certain nombre de pays ont ce problème de forte densité dans les centres urbains et pratiquement personne ailleurs. La Nouvelle-Zélande et l'Australie connaissent ces problèmes. Le problème c'est d'attirer des médecins dans ces régions. C'est un problème réel quand vous les payez à l'acte et qu'ils se retrouvent tous dans les centres urbains dont ils ne veulent pas bouger. Si vous les rémunérez selon une formule de capitation, ils bougeront.

Le sénateur Carstairs: Bien sûr. Là est tout le problème. Je suis originaire d'une province, le Manitoba, où nous avons une très grande ville, et ensuite nous avons Brandon et après pratiquement rien en termes de nombre. En cas d'urgence, le seul moyen c'est l'avion pour Winnipeg. Cela doit considérablement gonfler nos coûts comparativement aux Pays-Bas où, soyons honnêtes, une ambulance suffit pratiquement n'importe où.

M. Stabile: Il existe des études qui comparent, en particulier, le Manitoba à certains États des États-Unis qui ont des distributions

distributions, and we are doing okay compared to them, in terms of cost spending. They tend to spend more.

Senator Carstairs: The other issue that is of concern to me is capitation. I think it has been clear that, if every physician that was a general practitioner particularly or family physician were on capitation, you might be able to establish the protocols for testing, for technologies, for all kinds of things, but frankly there is not any incentive now. If a woman had a difficult pregnancy, yes, she might need eight ultrasounds, but in a normal pregnancy probably one ultrasound is adequate. What do you do if that patient demands six ultrasound during her treatment and threatens the doctor that she will go elsewhere if she does not get those six ultrasounds? At \$125 each, which was the price when I last looked, that becomes a significant drain on the health care system. How do we get to capitation?

Ms Flood: It depends on the form of capitation. You have to make a decision about how much the family doctor is going to be responsible for, and to what extent. You can go the whole hog and make them responsible for basically all hospital services, drugs, X-rays, and so on, or you can make it more manageable because obviously there is only so much financial risk that they will be able to bear. When GP fund holding started in the U.K., they just extended it to drugs and lab tests and X-rays and elective surgery. If you want to extend it further, you have to get them to come together and be in larger risk-bearing groups. There also has to be a mechanism whereby if, for example, a GP is in a particularly needy area there will be a risk-pooling mechanism to top him up. If a physician is in an area where every third person has HIV, then obviously there will have to be more of a capitated budget. Figuring out how to risk-rate and weight those capitated budgets is the biggest impediment to capitation. However, the Netherlands is a great place to look to actually figure out how to do this. They have done a lot of work on what you have to figure out to make that work.

Senator Carstairs: I would say the biggest difficulty is the culture of the physicians. We can go back to when we started this process in 1965. Tom Kent was very clear in his presentation the other day when he said, "Sure, we would have liked to have gone to capitation. We could not. There was not a culture among the physicians in the country and a willingness to move to capitation." How are we going to set the stage so that physicians will move to capitation?

Ms Flood: We will have to buy them off. It is the only way that ever worked in any country. They will have to be given the kind of capitated budget that will give them the autonomy and money they will want to make them feel good about it.

Senator Carstairs: In other words, if they are getting \$85,000 on average after costs, we have to offer them \$100,000 a year guaranteed?

Ms Flood: It would be worth it in the long run.

Senator Banks: Tell that to the NHL.

de population analogues et nous nous sortons très bien de ces comparaisons en termes de coûts. Ils ont tendance à dépenser plus.

Le sénateur Carstairs: L'autre question qui m'inquiète, c'est la capitation. Je crois qu'il est clair que si tous les médecins, les généralistes ou les médecins de famille, tout particulièrement, étaient payés suivant la capitation, on pourrait fixer des protocoles d'utilisation pour les analyses, l'équipement technologique, et cetera, mais personne ne semble en vouloir pour le moment. Si une femme connaît une grossesse difficile, oui, il est possible qu'elle ait besoin de huit ultrasons mais lors d'une grossesse normale il est probable qu'un seul ultrason soit suffisant. Que faites-vous si cette patiente demande six ultrasons pendant son traitement et menace le médecin d'aller voir ailleurs s'il ne lui prescrit pas ses six ultrasons? À 125 \$ la séance, c'était le prix la dernière fois que j'ai regardé, cela devient lourd pour le système de santé. Comment parvenir à la capitation?

Mme Flood: Cela dépend de sa forme. Il vous faut décider du degré de responsabilité à accorder au médecin de famille. Vous pouvez lui confier toutes les responsabilités, la responsabilité pour pratiquement tous les services hospitaliers, les médicaments, les rayons X, et cetera, ou vous pouvez lui donner des responsabilités plus gérables car il est évident qu'il y a des limites au risque financier qu'il sera prêt à assumer. Lorsque les généralistes au Royaume-Uni ont commencé à cotiser à une caisse d'assurance, cette caisse ne couvrirait que les médicaments, les analyses de laboratoire, les rayons X et les interventions chirurgicales bénignes. Pour pouvoir leur confier plus de responsabilités, il faudrait qu'ils cotisent tous à cette caisse pour qu'elle ait les reins plus solides. Il faut aussi que le généraliste qui accepte de travailler dans un secteur particulièrement difficile puisse bénéficier d'un mécanisme de solidarité. Si un médecin travaille dans un secteur où une personne sur trois est séropositive, il est évident que sa seule cotisation ne lui permettra pas de se couvrir. Calculer le risque et s'assurer en conséquence est le plus gros obstacle à la formule de capitation. Cependant, c'est vers les Pays-Bas qu'il faut se tourner pour voir comment cela peut marcher. Ils ont étudié tout ce qui devrait être étudié avant de mettre leur système en place.

Le sénateur Carstairs: Je dirais que le plus gros problème c'est l'attitude des médecins. Il suffit de revenir au tout début en 1965. L'autre jour, Tom Kent nous a clairement dit que l'option préférée c'était la capitation. Cela n'a pas été possible. Les médecins n'en voulaient pas. Que faire pour qu'ils changent d'attitude?

Mme Flood: Il faudra les acheter. C'est la seule solution qu'on ait trouvée partout ailleurs. Il faudra leur accorder le genre de budget par capitation qui leur donnera l'autonomie et l'argent qu'ils voudront pour se sentir à l'aise.

Le sénateur Carstairs: En d'autres termes, si leur salaire est de 85 000 \$ en moyenne après retenues, il faudra leur garantir 100 000 \$ par an?

Mme Flood: À long terme, ce serait rentable.

Le sénateur Banks: Dites-le à la LNH.

Mr. Blomqvist: The other thing that I have been wrestling with here, and I am not sure if that was part of question, is trying to imagine a way of doing this by degrees. In other words, is it possible to offer people the option, if you are a doctor, to either go to capitation or to stay on fee for service? If that is done, then patients must be given the option of either going to a capitated doctor or to a fee-for-service doctor. If you do that, and if you think you save money by going to a capitated doctor, then you have to compensate the patient for going to the capitated doctor. Are we prepared to do that?

Ms Flood: Why do you have to compensate the patient?

Mr. Blomqvist: In order for a capitated system to work, a person must basically agree, first, not to go to any other doctor during the period of contract and, second, agree to abide by the doctor's recommendation. If a patient does not like the doctor's recommendation, the patient does not go to a specialist.

The Chairman: You cannot doctor shop.

Senator Carstairs: One trade-off surely would be that you are always going to have service. Right now, we have a disproportionate number of Canadians using walk-in clinics and hospital emergency rooms, at enormous costs. You could build that in.

Ms Flood: Quality of care and continuity of care are good things about capitation. More concern is given to ongoing health.

Mr. Stabile: We are in a tough situation. One of the things that allowed the U.S. to move towards more capitation was the fact that they found themselves with more doctors than they needed. When they found themselves in a situation of excess hospital capacity, excess doctor capacity, they were in a situation where they could say, "Listen, we are going to offer you a bigger chunk."

The Chairman: That is buying off when you have excess supply. The principle is the same.

Mr. Stabile: It is a much easier situation than we have now.

Senator Banks: I am anxious to hear how the management that you have mentioned would work. I come from a show business background, and I believe this problem to be insoluble. I think it is precisely analogous. The problem of the dynamic and incompatibility between the artistic director of the ballet company and the manager of the ballet company, or theatre or orchestra, is insoluble. It is like Northern Ireland. How would it apply to health care? I am seeing a manager saying to a doctor, "Well, you can't see that guy again," or, "You can't suggest that he go to this specialist." The doctor would say, "I am a doctor." This is notwithstanding that the manager may also be a doctor. There will be a friction there.

Ms Flood: Friction, in my opinion, is fine. Friction is probably fine because there must be some resolution, some balancing. The

M. Blomqvist: L'autre chose que je me demande, et je ne suis pas certain que cela fasse partie de la question, c'est si l'on peut trouver un moyen d'y parvenir par degrés. En d'autres termes, est-il possible d'offrir aux médecins le choix entre le paiement par capitation ou rémunéré à l'acte? Dans un tel cas, il faudrait donner aux patients le choix de consulter un médecin payé par capitation ou un médecin payé à l'acte. Si c'est la solution, et si vous pensez que consulter un médecin payé par capitation est plus économique, il faut alors indemniser le patient qui décide de le faire. Est-ce que nous sommes prêts à le faire?

Mme Flood: Pourquoi indemniser le patient?

M. Blomqvist: Pour qu'un système fondé sur la capitation fonctionne, il faut que les patients, pour commencer, acceptent de ne pas consulter d'autres médecins pendant la durée du contrat et, deuxièmement, acceptent les recommandations du médecin. Si un patient n'aime pas la recommandation du médecin, il va voir un spécialiste.

Le président: Vous ne pouvez plus consulter un autre médecin si la recommandation du premier ne vous plaît pas.

Le sénateur Carstairs: Un avantage certain c'est de pouvoir toujours compter sur un service. À l'heure actuelle, il y a un nombre disproportionné de Canadiens qui consultent dans des cliniques ou qui encombrant les salles d'urgence à un coût énorme. Il faudrait en tenir compte.

Mme Flood: La qualité et la continuité sont deux atouts de la capitation. L'évolution de la santé des patients est mieux suivie.

M. Stabile: La situation est délicate. Si les États-Unis ont fini par opter pour la capitation c'est parce qu'ils se sont retrouvés avec plus de médecins qu'ils n'en avaient besoin. Lorsqu'ils se sont retrouvés avec trop de services hospitaliers, trop de médecins, ils ont pu dire: «Nous nous proposons de vous offrir une plus grosse part du gâteau».

Le président: C'est le principe d'exclusion par voie d'achat quand l'offre est excédentaire. C'est le même principe.

M. Stabile: Leur situation est beaucoup plus simple que la nôtre.

Le sénateur Banks: J'aimerais beaucoup que vous nous disiez comment cela fonctionnerait sur le plan administratif. Je viens du monde du spectacle et, à mon avis, c'est un problème insoluble. Je crois qu'il est tout à fait analogue. Le problème de la dynamique et de l'incompatibilité entre le directeur artistique d'une compagnie de ballet et l'administrateur de la compagnie de ballet, ou de théâtre ou d'orchestre, est insoluble. C'est comme la situation en Irlande du Nord. Comment cela fonctionnera-t-il dans le domaine de la santé? Je vois bien un administrateur dire à un médecin: «Vous ne pourrez plus revoir ce patient», ou «Vous ne pouvez lui recommander d'aller voir ce spécialiste». Le médecin répondra: «Je suis médecin». Même s'il peut arriver que l'administrateur soit aussi médecin. Il y aura forcément des frictions.

Mme Flood: Les frictions ne me dérangent pas. Elles sont même probablement souhaitables car elles ne peuvent aboutir qu'à

manager is representing societal interests. There are society's larger interests and then the individual patient's interest.

Senator Banks: He is a benevolent dictator.

Ms Flood: There is a balance that has to be reached between what is in the best interests of us as a society and what is in the best interests of individual patients. Individual patients, as I have said, will want everything. We all want everything when we are sick. It is all fine when we are not sick, but once we are sick, we want all the bells and whistles. We want everything, including the white rabbit out of the hat. At some point, there must be a balance. You raise a very good point on the difficulty between managers and physicians. It is like herding cats. Physicians do not like to be managed.

The point is, though, that we have not even tried. We do not have a culture of it because it was never done. Of course there will be difficulties at first. It will be hard. Managed care is problematic in the United States. That does not mean we should not be doing it.

I liked the U.K. fund holding initiative. I think it was working well. It is a shame that Blair has decided to — well, he has actually exploded it. They have made it too big now. They are too big a group to do anything effective. You can give the physicians autonomy, give them the power to make the decisions, give them the budgets and encourage them to make decisions, and that is the other way to go.

Mr. Stabile: It also goes back to the question of how much information we have about how people provide care across the country. We can say to a doctor, "Look, we have 200 other doctors who do the same thing you do and they do not use as many resources and do not have patients dying on them. Why is your use so different? We have other doctors who behave differently without the same outcomes. Why is your use different?"

Ms Flood: If I were a patient, I would really like to know that, actually.

[Translation]

Senator Gill: Health services have been improved. Everyone agrees with that. Life expectancy has increased, the infant death rate has decreased, etc. However, we have taken away people responsibilities. Earlier on, someone mentioned disorganization. From time to time, some disorganization is necessary to allow people able to become more responsible. We dig ourselves in even deeper by not making people able to shirk their responsibilities. The government takes charge of all care, and costs. In what direction should we go to try and make families responsible? People should become somewhat more responsible and we should not leave all of that up to the government.

[English]

Mr. Blomqvist: One of the disappointing fields of medicine, in my opinion, has been the notion of trying to instil in populations healthier habits to reduce health care costs. I think we all feel good about things like ParticipAction and smoking cessation

de bonnes solutions équilibrées. L'administrateur représente les intérêts de la société. Il y a les intérêts plus généraux de la société et les intérêts du patient.

Le sénateur Banks: C'est donc un dictateur bienveillant.

Mme Flood: Il faut parvenir à un équilibre entre les intérêts de la société et les intérêts du patient. Comme je l'ai déjà dit, les patients veulent tout. Nous voulons tout quand nous sommes malades. Il n'y a pas de problème tant que nous sommes bien-portants, pas malades, mais une fois malades, nous voulons avoir accès à tout. Nous voulons tout, y compris le haut-de-forme et le lapin blanc. Il faut arriver à un juste milieu. Vous avez tout à fait raison de parler de problème de frictions entre les administrateurs et les médecins. C'est comme vouloir faire défilé des chats. Les médecins n'aiment pas être administrés.

Il reste que nous n'avons même pas essayé. Nous n'en savons rien parce que nous n'avons jamais essayé. Bien entendu, au départ, il y aura des difficultés. Ce sera difficile. Aux États-Unis, cette formule de soins gérés ou administrés pose des problèmes. Cela ne veut pas dire que nous ne devrions pas essayer.

J'aimais bien l'initiative qui consiste à confier aux généralistes la gestion d'un budget. Je trouvais que cela fonctionnait bien. Il est malheureux que Blair ait décidé de — en fait, il l'a pratiquement fait exploser. Elle a pris des proportions incontrôlables. Le nombre de participants la rend ingérable. Vous pouvez donner aux médecins leur autonomie, leur donner le pouvoir de prendre des décisions, leur donner des budgets et les encourager à prendre des décisions, c'est ça l'autre solution.

M. Stabile: Cela nous ramène au point d'interrogation sur les normes de prestation d'un bout à l'autre du pays. Nous pouvons dire à un médecin: «Il y a 200 autres médecins qui font la même chose que vous et qui n'utilisent pas autant de ressources que vous mais qui n'en perdent pas pour autant de patients. Pourquoi cette différence? Nous avons d'autres médecins qui agissent différemment sans que cela coûte autant. Pourquoi cette différence?»

Mme Flood: En fait, si j'étais patient, j'aimerais aussi beaucoup le savoir.

[Français]

Le sénateur Gill: Les services de santé ont été améliorés. Tout le monde est d'accord là-dessus. La longévité des gens a augmenté, le taux de mortalité infantile a baissé, et cetera. Par contre, on a déresponsabilisé les gens. Tantôt, quelqu'un mentionnait la désorganisation. De temps en temps, il faudrait se désorganiser pour permettre aux gens de devenir davantage responsables. On s'enfonce davantage dans l'abîme lorsqu'on déresponsabilise les gens. L'État supporte tous les soins, tous les frais. Vers quoi nous dirigeons-nous pour faire en sorte que les familles soient responsables? On devrait acquérir une certaine responsabilité et on ne devrait pas laisser tout cela à l'État.

[Traduction]

M. Blomqvist: Une des déceptions dans le domaine de la santé, à mon avis, ce sont ces campagnes incitant la population à mener une vie plus saine dans le but de réduire les coûts de santé. Tous ces programmes comme ParticipAction, ces campagnes contre le

programs and the like, but the evidence that that has had a significant effect on health care costs is not great. The other option for doing this is trying to give a break on the insurance — in other words, lower premiums or lower taxes for people who have healthier habits, like non-smokers. Again, I do not think the evidence is particularly encouraging when it comes to that.

I honestly think there is not much of an option other than having societal evaluations of new technologies when they come in and then simply making a social choice that either you get this technology or you do not. For the opportunities of actually getting people to prevent ill health, the evidence is not there.

Ms Flood: You are talking about perhaps the possibility of user charges and things like this.

Senator Gill: Yes.

Ms Flood: The problem with health care is the doctor. Essentially, you go in to see a doctor to tell you what you need. The doctor mediates your exchange with the larger health care system. That is why focusing on patients and charging patients more is not necessarily the best way to go. There is just no evidence that supports this. In New Zealand, they have user charges just to go to see your doctor. We really have problems with health outcomes. We have worse infant mortality. We have concerns about access to care for people on lower incomes. Even though there are government subsidies for the poorer people, they still have to pay about 50 per cent of the cost. You do not want to stop people actually getting into the system, because often they cannot self-diagnose. You want them to get into the system, but then you need the physician to mediate their relationship with the rest of the system.

Inspiring healthier habits and trying to get them to be healthier needs to be encouraged from inside the physician-patient relationship. The physician needs to be telling patients to quit smoking, for example. Physicians will have more incentive to do that if they have more incentive to be concerned about the total costs of care for that patient.

Mr. Stabile: This is particularly important with children and the poor. Studies that have looked at whether using more health care actually helps you be healthier have found very few results except with children and the poor, where there is a lot of evidence that you have to get the children looked at by the doctor. The results are actually very noticeable.

The Chairman: That is a wonderful line to close on.

Tomorrow, we open with CIHI, the Canadian Institute for Health Information. One of their opening points is that there appears to be, in many ways, not a very strong correlation between consumption of health services by an individual and whether that person is in fact healthier, which is counter-intuitive to many positions.

As you can tell from the questions, we could have gone on for several hours. Thank you very much for this terrific overview. We will be back you to in the fall when we get into a much more intensive study of what we can really learn from other countries.

tabac, et cetera, nous donnent bonne conscience, mais l'incidence sur la réduction des coûts de santé est loin d'être probante. L'autre moyen d'y arriver c'est de jouer sur les primes d'assurance — en d'autres termes, les réduire, voire réduire les impôts de ceux qui mènent une vie plus saine, comme par exemple les non-fumeurs. Encore une fois, l'incidence sur la réduction des coûts n'est pas particulièrement encourageante.

Je crois honnêtement qu'il n'y a guère d'autre solution que d'évaluer l'incidence des nouvelles technologies lorsqu'elles arrivent sur le marché, et de faire un simple choix social: les accepter ou les rejeter. Quant aux campagnes de vie plus saine, les résultats ne sont pas probants.

Mme Flood: Vous parlez, je suppose, du concept d'utilisateur-payeur.

Le sénateur Gill: Oui.

Mme Flood: Le problème dans le domaine de la santé c'est le médecin. Si vous allez voir un médecin c'est pour qu'il vous dise ce dont vous avez besoin. Le médecin est votre intercesseur auprès du système de santé. C'est la raison pour laquelle se fixer sur les patients et leur faire payer plus n'est pas forcément la meilleure solution. Nous n'avons tout simplement pas de quoi le justifier. En Nouvelle-Zélande, si vous allez voir votre médecin, c'est vous qui payez. Il y a des problèmes réels au niveau des conséquences. La mortalité infantile augmente. Il y a le problème d'accès pour les revenus faibles. Même si le gouvernement subventionne les plus démunis, ils doivent quand même payer 50 p. 100 du coût. Vous ne voulez pas empêcher les gens d'avoir accès au système car dans la majorité des cas ils ne peuvent pas s'autodiagnostiquer. Vous voulez qu'ils aient accès au système mais il faut que le médecin leur serve d'intercesseur avec le reste du système.

Inciter la population à vivre plus sainement ne peut aboutir à des résultats que dans le contexte d'une bonne relation médecin-patient. C'est au médecin de dire à ses patients d'arrêter de fumer, par exemple. Et ce médecin sera d'autant plus incité à le faire si le coût total de la santé de ce patient correspond à une incidence directe pour lui.

M. Stabile: C'est tout particulièrement important pour les enfants et les indigents. Les études examinant si le recours fréquent à la médecine permettait vraiment d'être en meilleure santé ont été très peu concluantes, sauf dans le cas des enfants et des indigents, où on a la preuve que l'intervention des médecins est bénéfique. Les différences sont très visibles.

Le président: Merveilleuse manière de conclure.

Demain, nous entendrons les représentants de l'Institut canadien d'information sur la santé. L'un des postulats qu'ils avancent est qu'il semblerait, à de nombreux égards, qu'il n'y a pas de forte relation de cause à effet entre la consommation de services de santé par un individu et un état de santé généralement supérieur, ce qui contredit nombre d'idées reçues.

Comme vous pouvez en déduire d'après le nombre de questions qui vous ont été posées, nous aurions pu continuer pendant des heures. Nous vous remercions infiniment de ce tour d'horizon fort instructif. Nous ferons de nouveau appel à vous à l'automne, quand nous serons entrés dans une phase beaucoup plus intensive

In the meantime, in thinking about it, if you find that you have a compendium of options or policies that have been used to deal with the incentive systems in a variety of ways, I would like to see one, even just in bullet points. That would be great. Thank you very much for attending.

The committee adjourned.

OTTAWA, Thursday, May 11, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 11:10 a.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[English]

The Chairman: Honourable senators, we are here to continue our series of hearings on the state of the health care system in Canada and, in particular, to continue our hearings on our first volume, which is designed to give background information and to bring people — not only members of the committee, but those who end up reading the report — up to date on the series of facts surrounding the current state of the health care system. We deal in that report with many of the myths that are floating about.

Today, our first witness is Dr. John Millar from the Canadian Institute for Health Information. He will present the highlights of his report, and then we will ask him some questions related to that. Welcome, doctor, and please proceed.

Dr. John S. Millar, Vice-President, Research and Analysis, Canadian Institute for Health Information: I apologize that I do not have French copies of the report here. We just could not open that vault this morning.

I thank you for this opportunity to present some of the highlights of this report to you. It is always gratifying for those of us who toil away in the field of health information to have that information put before those who are in a position to affect policy; I therefore welcome this opportunity.

This report came out on April 26. It is the first report that we have produced. It is a report that was produced in partnership with Statistics Canada. I should mention that the Canadian Institute for Health Information is an organization that was set up in 1994 by the joint efforts of the federal and provincial Ministers of Health to be an independent, non-profit organization in the business of providing the best available objective evidence on two big questions: First, how healthy are Canadians? Second, how well is the health care system performing? Our intent is to answer those two large questions.

de l'examen de ce que la situation dans d'autres pays peut nous apprendre.

Entre-temps, si vous y réfléchissez et que vous finissez par mettre la main sur une liste d'options ou de politiques ayant été utilisées pour mettre en place ce genre de systèmes sous différentes formes, j'aimerais la voir, même sous forme de cartouche. Ce serait formidable. Merci d'être venus.

La séance est levée.

OTTAWA, le jeudi 11 mai 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit ce jour à 11 h 10 pour examiner le système de santé du Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[Traduction]

Le président: Honorables sénateurs, nous reprenons aujourd'hui nos audiences sur le système de santé du Canada. Nous voulons en particulier poursuivre les audiences consacrées à notre premier volume, qui est destiné à recueillir des informations générales de façon à ce que les gens — pas seulement les membres du comité mais aussi les lecteurs du rapport — possèdent des renseignements à jour sur la situation actuelle du système de santé. Nous traiterons notamment dans ce rapport des nombreux mythes qui semblent entourer le système.

Notre premier témoin est le Dr John Millar, de l'Institut canadien d'information sur la santé, qui va nous présenter son rapport, après quoi nous aurons une période de questions. Je vous souhaite la bienvenue, docteur. Vous avez la parole.

M. John S. Millar, vice-président, Recherche et analyse, Institut canadien d'information sur la santé: Veuillez m'excuser, je n'ai pas d'exemplaires du rapport en français. Nous n'avons tout simplement pas réussi à ouvrir le coffre-fort.

Je vous remercie de me donner l'occasion de présenter les points saillants de ce rapport. Il est toujours satisfaisant, pour quiconque oeuvre dans le secteur de l'information sur la santé, de pouvoir présenter les résultats de son travail à ceux qui sont en mesure d'influer sur les politiques.

Ce rapport a été publié le 26 avril. C'est notre premier rapport, qui a été produit en collaboration avec Statistique Canada. Je dois peut-être préciser que l'Institut canadien d'information sur la santé a été mis sur pied en 1994 suite aux efforts communs des ministères fédéral et provinciaux de la Santé dans le but d'établir un organisme indépendant et à but non lucratif chargé de produire les meilleures données objectives possibles sur deux grandes questions: premièrement, quel est le bilan de santé des Canadiens; deuxièmement, le système de santé fonctionne-t-il comme il le devrait? Nous avons l'intention de répondre à ces deux grandes questions.

This particular report is the second of two. An earlier report in March, issued by Statistics Canada, answered the question about how healthy Canadians are. This report is talking more specifically about the health care system, using the best available data and drawing on data at a variety of levels across the country with an expert group that involved many illustrious academics and practitioners across the country.

The first thing to draw to your attention in the report is that global question of how healthy Canadians are. This is something that I am not sure is widely appreciated. Over the past several decades, the health of Canadians has been going up and up and up, surpassing all other countries. We are now second in the world in terms of our life expectancy, second only to Japan. I would anticipate before long that we will be number one. We are increasing at a rate that is even more rapid than that of Japan, and Japan is experiencing some difficulties.

Within that overall good news story about the health of Canadians, there are some more disturbing stories, because certainly not all Canadians enjoy that high level of good health. Aboriginal people, particularly, have a life expectancy that is five, seven or twelve years different, depending on how you measure it. Certainly, people in northern, rural, and low-income, urban areas have a remarkably lower life expectancy than more affluent Canadians; so there are some problems.

You have a copy of the particular report before you, honourable senators. It does mention the life expectancy. It also goes into some details on the health care system. It documents some of the changes that have been taking place. The first and obvious change, outside of Ontario, is regionalization. Every other province is regionalized now, and they are beginning to show signs of truly being able to integrate services. That has been a major change.

The other major change is health care spending. I will show you some more details on how the spending has changed. This slide shows the public and private expenditures per capita in constant dollars. You can see that, through the 1970s and 1980s, there were constant, real-dollar increases in health care spending per capita, up until 1990, both in the public sector and in the private sector. Looking at that top graph, you see that in the mid-1990s it plateaued and began a period of real decreases in per capita health care expenditures in the public sector, whereas below, in the bottom graph, you see that private sector funding continued to increase unabated. That is the money people are paying out of pocket and through privately purchased insurance programs.

The Chairman: I want to be clear that we are talking about apples and apples. When you say "health care spending," can you tell me what services are included in that?

Ce rapport est en fait le deuxième de deux car Statistique Canada a publié en mars un premier rapport sur l'état de santé des Canadiens. Notre rapport à nous est plus précisément axé sur l'évaluation du système de santé lui-même, au moyen des meilleures données disponibles et de données obtenues par un groupe d'experts de l'ensemble du pays, comprenant de nombreux universitaires et praticiens réputés.

La première chose que je souhaite porter à votre attention concerne la question globale du bilan de santé des Canadiens. C'est quelque chose qui n'est peut-être pas bien compris par le public. Depuis plusieurs décennies, le bilan de santé des Canadiens ne cesse de s'améliorer, à un point tel que nous dépassons maintenant tous les autres pays. Nous sommes le deuxième pays au monde du point de vue de l'espérance de vie, juste après le Japon, et je m'attends à ce que nous passions au premier rang sous peu. Nous augmentons notre espérance de vie à un rythme encore plus rapide que le Japon, pays qui connaît en outre certaines difficultés.

Ce bon résultat général sur la santé des Canadiens ne doit cependant pas cacher certains éléments troublants, étant donné que ce ne sont certainement pas tous les Canadiens qui bénéficient de cette bonne santé. Les autochtones, en particulier, ont une espérance de vie qui est de cinq, sept ou 12 années inférieure, selon le critère utilisé. De toute façon, les gens des régions du Nord, des zones rurales et des zones urbaines à faibles revenus ont une espérance de vie remarquablement plus faible que les Canadiens plus prospères. Il y a donc des problèmes.

Vous avez reçu un exemplaire du rapport concernant l'espérance de vie, honorables sénateurs, et vous verrez que l'on y traite aussi en détail de l'état du système de santé. On y parle de certains des changements qui se sont produits. Le premier, qui est aussi le plus évident, en dehors de l'Ontario, est la régionalisation. Une province sur deux est maintenant régionalisée et certains signes commencent à montrer qu'on est vraiment capable d'intégrer les services. Cela constitue un changement d'importance.

L'autre changement notable concerne les dépenses consacrées à la santé. Je vous montrerai bientôt en détail comment ces dépenses ont changé. Cette acétate montre que les dépenses publiques et privées par habitant, exprimées en dollars constants, ont augmenté pendant les années 70 et 80, jusqu'à 1990, tant dans le secteur public que dans le secteur privé. Le graphique du haut montre qu'elles ont atteint un plateau au milieu des années 90, après quoi on a enregistré une baisse réelle dans le secteur public alors que la hausse continuait de la même manière dans le secteur privé. Je parle ici de l'argent que les gens paient eux-mêmes ou par le truchement de régimes d'assurance privés.

Le président: Je voudrais m'assurer que nous parlons bien des mêmes choses. Quand vous parlez de «dépenses de santé», qu'est-ce que cela inclut?

I ask that because, for instance, federal money for health care goes toward doctors and hospitals. I presume you are including a lot more than that. Is that right?

Dr. Millar: Absolutely, yes. I am including hospitals, doctors, some drugs, some home care, some nursing home care and some mental health services. It is mixed. The ones that are virtually entirely publicly funded are hospitals and doctors. However, when you get into the question of drugs, it is a mixture. When you get to home care, long-term care and mental health services, they are all a mix of public and private.

The Chairman: In terms of health care spending, when you say "long-term care," what are you including?

Dr. Millar: Everything.

The Chairman: In regard to nursing homes, you are referring to the full cost, some of which is funded through both public and private monies. However, when you say health care, you are including all those things.

Dr. Millar: Yes.

The Chairman: I ask the question because frequently from the federal side we use the words "health care" but we do not really mean health care; we mean medicare and hospital insurance.

Dr. Millar: This is much broader. It is all the public money being spent by federal and provincial governments on the health services that they provide.

The Chairman: As well as all the private money being spent on things that would remotely be called "health"; is that right?

Dr. Millar: Yes.

The Chairman: It is interesting to note that this report does not define what you mean by "health care."

Dr. Millar: It defines the services. It shows what services are being included.

At the very top end of both those curves, you see white dots, which are the estimates for the last couple of years showing that the public sector per capita funding has begun to increase once again in 1998 and 1999. The private sector continues to increase.

As a consequence, if you had taken a snapshot in 1997 looking at the per capita expenditures in Canada compared with other countries, you would see, as on this slide, that Canada is in fact fourth in the world among the G-7 countries in overall spending and is fourth in public sector spending. This is a very interesting slide. The United States spends more per capita out of tax dollars on health care than does Canada. They also spend more in terms of private expenditures, privately purchased insurance and out-of-pocket expenditures, than do Canadians. Yet, Canadians are almost the healthiest people in the world, whereas the United

Je pose la question parce que, par exemple, les dépenses fédérales consacrées à la santé sont destinées aux médecins et aux hôpitaux. Je suppose que vous parlez de beaucoup plus que cela, n'est-ce pas?

M. Millar: Je veux parler des dépenses consacrées aux hôpitaux, aux médecins, à certains médicaments, à certains services à domicile, à certains centres de soins infirmiers et à certains services de santé mentale. Il s'agit donc de toute une gamme de choses mais les deux secteurs qui sont quasiment totalement financés à même les deniers publics sont les hôpitaux et les médecins. Quand on parle de médicaments, c'est un ensemble de dépenses publiques et privées, tout comme dans le cas des soins à domicile, des soins de longue durée et des services de santé mentale.

Le président: Quand vous parlez de dépenses consacrées aux «soins de longue durée», de quoi s'agit-il?

M. Millar: De tout.

Le président: Pour ce qui est des foyers de soins infirmiers, il s'agit du total des dépenses, c'est-à-dire aussi bien des dépenses publiques que des dépenses privées. Quand vous parlez de soins de santé, vous englobez toutes ces choses-là.

M. Millar: Oui.

Le président: Je pose la question parce que, souvent, quand on parle de «dépenses de santé», au palier fédéral, on ne parle pas vraiment de tous les services de santé mais plutôt des services de médecine et d'hospitalisation couverts par l'assurance.

M. Millar: Dans mon cas, c'est beaucoup plus large. Je parle de toutes les dépenses publiques consacrées par les gouvernements fédéral et provinciaux aux services de santé.

Le président: Ainsi que de tout l'argent privé qui est consacré à des choses qui ne sont reliées que de loin à ce que nous appelons «la santé»?

M. Millar: Oui.

Le président: Il est intéressant de constater que ce rapport ne contient aucune définition de ce que vous entendez par «soins de santé».

M. Millar: Mais on y définit les services. On y indique les services qui sont inclus.

En haut de ces deux courbes, vous voyez des points blancs qui représentent l'estimation des dépenses de santé du secteur public par habitant pour les deux dernières années, qui ont commencé à nouveau à augmenter en 1998 et en 1999. Les dépenses du secteur privé continuent aussi à augmenter.

En conséquence, si l'on avait pris un instantané en 1997 des dépenses par habitant au Canada et dans d'autres pays, on aurait constaté que le Canada est en fait au quatrième rang parmi les pays du G-7 pour ce qui est des dépenses globales, et au quatrième aussi pour ce qui est des dépenses du secteur public. Ce graphique est très intéressant. On voit que les dépenses de santé du secteur public, par habitant, sont plus élevées aux États-Unis qu'au Canada. Les États-Unis dépensent également plus dans le secteur privé, c'est-à-dire par le truchement des régimes d'assurance privés et des dépenses individuelles. Pourtant, les

States ranks twentieth-fifth in terms of life expectancy. It is a curious observation, and there are various interpretations around it. Some people look at this and say, "Obviously, we should be spending more in the Canadian public sector." Other people say, "Clearly, no. This reflects how efficient we are being. For those public dollars we are getting such good outcomes." Other people say, "Part of the reason we are doing so well is that we are spending relatively little on health care, which frees up public money for other things like education and social services that are health enhancing." There are various interpretations of that.

There have been huge shifts going on in the way health care dollars have been spent so that the amount spent on hospitals as a percentage has dropped considerably. It is now at 31.6 per cent; it used to be in the mid-40s. Physician expenditures as a percentage share have dropped, whereas the amount being spent on drugs has been continuously increasing. Thus, that is now the second major health care expenditure.

These changes in funding and the reductions in funding have clearly created a lot of stresses in the system. It has been accompanied by a 25 per cent reduction in hospital bed availability. There has been a shift over to more outpatient services. There are many stresses that have gone along with that. One of those is that public confidence has been eroded significantly. We certainly have very well documented in this report that there has been less access to some services, such as emergency rooms and some specialist services and procedures. As a consequence of that and as a result of media attention to it, public confidence has dropped quite considerably. As you can see from this slide, it has dropped from 50 per cent or 60 per cent of people expressing confidence in the system down to some 20-odd per cent, which is quite a dramatic reduction.

On the other hand, when you ask people who have actually been the recipients of care, they express very high levels of satisfaction. That reflects the fact that the provider groups, that is, doctors and nurses, despite all the stresses, have been struggling to continue to perform to a high level. The performance measures we have show that there are good outcomes. It is an interesting dichotomy, which shows up time and time again when these types of surveys are done.

Access to services is one of the things we are very interested in monitoring; this slide shows the difference in access to physician services between the 1950s and the 1990s by income group. Back in the 1950s, the higher your income, the more likely you were to have physician services; whereas in current times, your access to physician services is the same, whether you are low income or high income.

What has happened with all these bed cuts? As I have said, 25 per cent fewer beds are available. Day surgery has doubled. The attempts that have been made to measure the health impact of this have been quite surprising to us. They are documented in the

Canadiens font partie des gens les mieux en santé au monde, alors que les Américains se situent au vingt-cinquième rang du point de vue de l'espérance de vie. C'est une constatation curieuse, qui prête à diverses interprétations. Certaines personnes disent: «Nous devrions manifestement accroître les dépenses du secteur public au Canada». D'autres répliquent: «Bien sûr que non puisque nous sommes très efficaces. Nos dépenses publiques actuelles donnent d'excellents résultats.» D'autres encore disent: «Si nos résultats sont si bons, c'est en partie parce que nous dépensons relativement peu dans le secteur de la santé, ce qui libère des deniers publics pour d'autres choses, comme l'éducation et les services sociaux, qui contribuent à améliorer la santé des gens.» Il y a donc différentes interprétations possibles.

On a constaté d'énormes changements quant à la manière dont les deniers publics consacrés à la santé sont dépensés. Par exemple, les sommes consacrées aux hôpitaux ont considérablement baissé, proportionnellement parlant. Elles représentent maintenant 31,6 p. 100, alors qu'elles tournaient auparavant autour de 45 p. 100. La proportion des sommes consacrées aux médecins a elle aussi diminué, alors que celle consacrée aux médicaments augmente continuellement. Voilà donc la situation pour le deuxième secteur important des dépenses de santé.

Ces changements et la baisse des budgets ont manifestement provoqué beaucoup de stress dans le système. Cela s'est accompagné d'une baisse de 25 p. 100 dans la disponibilité des lits d'hôpitaux, avec un recours plus élevé aux services externes, ce qui a aussi engendré beaucoup de stress. Par exemple, la confiance du public a considérablement baissé. Nous montrons très bien dans ce rapport que certains services sont moins accessibles, comme les salles d'urgence et certains services de spécialistes. Comme cela a beaucoup retenu l'attention des médias, la confiance du public a considérablement diminué. Comme le montre cette acétate, la proportion de gens exprimant leur confiance envers le système, qui était de 50 p. 100 ou 60 p. 100, est tombée à quelque 20 p. 100, ce qui est tout à fait spectaculaire.

En revanche, quand on pose la question aux gens qui ont réellement reçu des soins, ils expriment des niveaux de satisfaction très élevés. Cela démontre que les gens qui dispensent les soins, les médecins et les infirmières, ont maintenu des niveaux de rendement très élevés malgré tous ces facteurs de stress. Les mesures du rendement dont nous disposons montrent de bons résultats. C'est une dichotomie intéressante qui apparaît constamment chaque fois que l'on fait des enquêtes de ce genre.

L'accès aux services est l'une des choses intéressantes à analyser. Cette acétate montre la différence d'accès aux services des médecins entre les années 50 et les années 90, par catégorie de revenu. Dans les années 50, plus le revenu était élevé, plus on était susceptible d'avoir des services de médecins. Aujourd'hui, cet accès est le même pour tout le monde, que le revenu soit faible ou élevé.

Qu'est-il arrivé avec la baisse d'accès aux lits? Comme je l'ai dit, le nombre de lits disponibles a baissé de 25 p. 100. La chirurgie de jour a doublé. Les tentatives de mesure de l'incidence de ce phénomène sur la santé ont donné des résultats surprenants.

report, which shows that in Saskatchewan, where some 32 rural hospitals were closed, the overall health status measures actually improved more rapidly in the communities where those small hospitals were closed. In Winnipeg, where this issue was studied, some 15 per cent of hospital beds were reduced. In fact, the overall health status measures continued to improve as well. That was a bit of a surprise in this study.

Senator Cohen: Why did that phenomenon happen?

Dr. Millar: There is a variety of possible reasons, but nobody knows precisely the reason. One possible explanation is that, if there was a small hospital available and there was major trauma, for example, the trauma went to that hospital where there were physicians and nurses who were not used to dealing with that level of trauma. As a result, there may have been delays in getting to the level of care needed. People are now going directly to a higher level and better qualified service.

Another of the major problems that the report shows — and everyone knows it is true — is that there has been emergency room congestion. This slide shows that that emergency room congestion is reflected by headlines. Those headlines from right across the country have tended to occur in December, January and February. It has been well shown in more detailed studies that that is connected to the annual flu epidemic. Much of the congestion, both in the emergency rooms and in hospital beds in that period of time is driven by respiratory disease and can be attributed to flu.

What has been shown in some more detailed study across the country is that, where there is good information on the reasons for that kind of congestion, programs have been put into place that have dealt with it. As the chair of the CIHI board is fond of saying, “You cannot manage what you cannot measure, but where you do have good measurement you can manage it.”

In Winnipeg, they brought in a program under which they increased flu immunization. They made the admissions and the discharges more efficient. They provided more bed availability during the peak season for flu. They provided more beds in the communities so that they could move bed blockers out of the hospitals. As a consequence of that intervention, they were able to avert the emergency room congestion that was experienced by many centres, such as Toronto, in the past winter.

What is going on with providers? It is not surprising that there is a lot of stress in the system, in particular among nurses where there is very good data now that shows that, amongst all the workforce categories, nurses are suffering more time off, more disability, more back pain, and so on. The nursing profession is clearly suffering. Nurses are also getting older.

The same thing applies to physicians. It is very much an older population, and the number of physicians has been declining slightly.

We are very interested in prevention and outcomes. In terms of some preventive measures, some data in here looks at mammography, for example, and early detection of breast cancer.

On en trouve des exemples dans le rapport, qui montre qu'en Saskatchewan, où quelque 32 hôpitaux ruraux ont été fermés, les indices généraux de santé de la population se sont améliorés plus rapidement dans les communautés où de petits hôpitaux ont été fermés. À Winnipeg, où l'on a étudié cette question, quelque 15 p. 100 des lits d'hôpitaux ont été fermés. Pourtant, le bilan de santé global a continué de s'améliorer. Cela a été l'une des surprises de cette étude.

Le sénateur Cohen: Qu'est-ce qui explique ce phénomène?

M. Millar: Plusieurs raisons sont possibles mais personne n'a encore trouvé la bonne. L'une des possibilités est qu'en cas d'accident grave, par exemple, la victime était auparavant aiguillée vers le petit hôpital local où elle était traitée par des médecins et infirmières n'ayant pas l'habitude de traiter des traumatismes graves. De ce fait, il y avait peut-être des délais dans l'obtention du niveau de soins requis. Aujourd'hui, cette victime serait aiguillée directement vers un service de plus haut niveau, plus qualifié.

L'un des principaux problèmes que montre le rapport — et tout le monde le sait bien — c'est celui des embouteillages dans les salles d'urgence. Cette acetate montre que ce phénomène fait la manchette des journaux. Les manchettes que vous voyez ici proviennent de tout le pays, de décembre à février. Le phénomène a également été clairement confirmé par des études plus détaillées reliées à l'épidémie de grippe annuelle. Une bonne partie des embouteillages, autant dans les salles d'urgence que dans les services d'hospitalisation, est attribuable pendant cette période aux maladies respiratoires et à la grippe.

Des études plus détaillées concernant l'ensemble du pays ont permis d'obtenir de bonnes informations sur les raisons de ce type d'embouteillage et sur les programmes qui ont été mis en oeuvre pour y faire face. À titre de président de l'ACIS, je me plais à dire qu'«on ne peut pas gérer ce qu'on ne peut pas mesurer».

À Winnipeg, on a renforcé l'immunisation contre la grippe et on a rendu les admissions et les congés plus efficaces. On a aussi accru la disponibilité des lits pendant la période de pointe de la grippe et on a installé plus de lits dans les communautés locales, de façon à pouvoir faire sortir des hôpitaux les malades monopolisant des lits. Cela a permis d'éviter les embouteillages dans les salles d'urgence qu'ont connus beaucoup d'autres collectivités l'hiver dernier, comme Toronto.

Qu'en est-il de ceux qui donnent les soins? Il n'est pas étonnant que l'on constate beaucoup de stress dans le système, surtout chez le personnel infirmier. Des données très solides montrent que, de toutes les catégories de personnel, c'est celle-là qui subit le plus de journées chômées, d'accidents du travail, de douleurs lombaires, et cetera. C'est manifestement le personnel infirmier qui est le plus pénalisé. En outre, ses membres ne rajeunissent pas.

La même chose vaut pour les médecins. C'est dans l'ensemble une population plus âgée, et le nombre de médecins a enregistré une légère baisse.

Nous attachons beaucoup d'importance à la prévention et aux résultats. Pour ce qui est des mesures de prévention, nous avons des données sur la mammographie, par exemple, et sur la

It shows that there are quite considerable differences by province in the achievements being made there. Similarly, in immunization, although we believe one of the big areas that we do not have good data on in the country is immunization rates, we do have good data on communicable disease rates, and it is a good news story there. We have been able to eliminate smallpox and polio and almost eliminate measles, and there is good news around immunization. However, there are many ongoing challenges in getting good data and trying to bring everyone up to the same level of high performance.

In terms of appropriateness of care, we have taken a look at the caesarean section rate across the country. The WHO recommends a caesarean section rate between 10 and 15 per cent. The overall rate in Canada has been climbing over the last few years. There was an attempt through the Society of Obstetricians and Gynaecologists of Canada to reduce the rate, and it went down for a while. However, it is back on the rise again. In some jurisdictions, they do extremely well. There are jurisdictions in Quebec, for example, where the caesarean section rate is as low as 13 per cent. There are jurisdictions on the West Coast that are up in the 25 or 27 per cent range. There is a huge variability. We do not have a full explanation for that at this time.

Senator Carstairs: Do you have statistics based on the time of day at which the C-sections are done?

Dr. Millar: No. It is not recorded in our database as to what time they are done.

The Chairman: Why did you ask that?

Senator Carstairs: Anecdotal experience would tell that you C-sections are done so that doctors can get a good night's sleep. They are not done between midnight and eight. They tend to be done up to midnight. If the labour is going to progress longer through the period of time, the C-section is done.

Dr. Millar: Our intent here in providing this data is to have that type of analysis done by the managers and providers at a local level so that, when they do have very high rates, they can identify exactly that kind of issue. We also know that in some areas it is driven by women's preferences. Some women prefer to have caesarean sections. There is a variety of explanations there.

In terms of outcomes, there is a recurrent theme in this report about the things we do not know. Again, it comes as a surprise to many people when they realize that we cannot report on good outcome data for many procedures that are done. Where we do have those data, we have presented it.

We do have an organ replacement registry that is operated by CIHI. From that, we have been able to show that the survival rates for kidney, heart and liver transplants are comparable across the country. There is good performance right across the country and good performance by comparison internationally. It is similar with communicable disease control and with rehabilitation outcomes. We do have some outcomes in those areas. It comes as a major surprise to many people that, for example, the leading cause of deaths is, as I am sure Dr. Keon has made known to you and to others, heart disease.

détection précoce du cancer du sein. Elles montrent qu'il y a des différences de résultats considérables d'une province à l'autre. De même, en immunisation, même si nous pensons que c'est l'un des domaines importants pour lesquels nous n'avons pas de bonnes données de portée nationale, les bonnes données que nous possédons au sujet des maladies transmissibles sont fort encourageantes. Nous avons en effet réussi à éliminer la varicelle et la poliomyélite, et presque totalement la rougeole, ce qui constitue un très bon résultat. Par contre, nous avons encore des défis à relever pour recueillir de bonnes données d'ensemble.

Pour ce qui est du caractère approprié des soins, nous avons examiné la situation des césariennes dans l'ensemble du pays. L'OMS recommande le recours à la césarienne dans 10 p. 100 à 15 p. 100 des cas. Or, la proportion globale au Canada a augmenté ces dernières années. La Société des obstétriciens et gynécologues du Canada a mené une campagne pour tenter de faire baisser le taux, et c'est ce qui s'est produit pendant un certain temps. Par contre, la proportion a maintenant recommencé à monter. Dans certaines régions, les résultats sont très bons. Au Québec, par exemple, le taux de césariennes est aussi bas que 13 p. 100 dans certaines régions. Sur la côte Ouest, en revanche, on atteint parfois 25 p. 100 à 27 p. 100. Il y a donc de grandes différences que nous sommes encore incapables d'expliquer.

Le sénateur Carstairs: Avez-vous des statistiques sur le moment de la journée auquel sont effectuées les césariennes?

M. Millar: Non, cette information ne figure pas dans notre base de données.

Le président: Pourquoi?

Le sénateur Carstairs: Certaines données empiriques montrent que les césariennes sont faites pour que les médecins puissent dormir en paix. On n'en fait pas entre minuit et 8 heures du matin mais plutôt jusqu'à minuit. Si le travail doit continuer après minuit, on fait une césarienne.

M. Millar: En recueillant ces données, notre objectif est de permettre aux gestionnaires et aux responsables des soins au niveau local de faire ce type d'analyse et d'en tirer leurs conclusions. On sait aussi que, dans certaines régions, cela tient aux préférences des femmes. Certaines préfèrent avoir une césarienne. Il y a donc plusieurs explications possibles.

En ce qui concerne les résultats, un thème revient souvent dans ce rapport au sujet de ce que nous ne savons pas. En effet, bien des gens seront surpris de réaliser que nous ne sommes pas en mesure de fournir de bonnes données sur les résultats de nombreuses procédures. Lorsque nous avons ces données, nous les présentons.

L'ICIS exploite un registre des greffes d'organes. Cela nous a permis de constater que les taux de survie après des greffes de reins, de coeurs et de foies sont comparables d'un bout à l'autre du pays. On enregistre à ce sujet de bons résultats dans tout le pays ainsi qu'à l'échelle internationale. C'est la même chose que pour le contrôle des maladies transmissibles et la réadaptation fonctionnelle. Nous avons quelques résultats dans ces domaines. Beaucoup de gens sont très surpris, par exemple, que les maladies du coeur soient la principale cause de décès, et je suis sûr que le Dr Keon l'a déjà indiqué.

We cannot report on outcomes for acute myocardial infarction, how many people live and die, in a standardized way across the country. We simply do not have that data. We cannot report on how well people do with cancer or for major trauma or diabetes or for many of the common disease entities. We simply do not have, at the moment, any routine outcome reporting ability. We are working on that, and I am confident that in the course of the next few years for which we have the funding, we will be able to begin to fill in some of those blanks.

There are many other questions that we cannot answer. We do not have very good expenditure data at a regional level or by sector. As I have mentioned, we do not have good information on outcomes. We do not have good wait list data. One of the hottest political issues is how long people are waiting for procedures. There is no standardized way of reporting that. Safety is another major concern of the public: when people go into hospital, will they get the right treatment at the right time? That is an area that we regard as a high priority, and we are developing ways to attempt to measure that.

Mr. Chairman, I will stop there and attempt to answer any questions you may have.

The Chairman: Thank you. May I ask you some procedural questions? Procedurally, do you intend to produce an annual report?

Dr. Millar: Yes, we are committed to producing an annual report. It will not necessarily be as biblical as this. We will certainly have not only an annual report but also a series of reports coming out through the course of the year reporting on various aspects of the health care system.

The Chairman: We should make sure that when those come out, they go to all members of the committee. On your list of unanswered questions, I picked the "waiting line" as an example where you say there are no data. Are you in the process of putting in place an information system that will get that data?

Dr. Millar: Yes, we are. We already have in place a system that will be able to provide standardized information on emergency room wait times. That is in place, and we expect to have data flowing there within the next year. When it comes to waits for heart transplants or cardiac care or cancer treatments or cataracts or hip replacements, those are more difficult, but we are attempting to work with various professional groups to get those kinds of wait times as well.

The Chairman: Do you hope to be able to get that information in the next year or so, or is that some distance off?

Dr. Millar: I would hope to have some of those in the next year or so, but it is a struggle. It is not easy to do.

Par contre, nous n'avons pas d'information sur les résultats de l'infarctus aigu du myocarde, c'est-à-dire sur le nombre de personnes qui meurent ou qui survivent, pour l'ensemble du pays. Nous n'avons tout simplement pas de chiffres à ce sujet. Nous ne pouvons pas dire non plus quelle est la situation pour les personnes atteintes du cancer ou qui ont subi un traumatisme grave, ni même pour le diabète ou pour bon nombre d'autres maladies courantes. Nous n'avons tout simplement pas, pour le moment, la possibilité d'obtenir des données régulières à ce sujet. Certes, nous essayons de résoudre ce problème et j'ai la conviction que nous pourrions commencer à remplir certains des blancs d'ici à quelques années, lorsque nous aurons obtenu plus de fonds.

Il y a beaucoup d'autres questions auxquelles nous ne pouvons pas répondre. Nous n'avons pas de très bonnes données sur les dépenses au niveau régional ou sectoriel. Comme je l'ai déjà dit, nous n'avons pas de bonnes informations sur les résultats. Nous n'en avons pas non plus sur les listes d'attente. L'une des questions les plus controversées, au niveau politique, concerne le temps que les gens passent en salle d'attente. Il n'existe pas de méthode standardisée pour recueillir des données à ce sujet. La sécurité est l'une des principales préoccupations de la population. Quand les gens entrent à l'hôpital, obtiendront-ils le traitement voulu, au moment voulu? Cette question constitue pour nous l'une des plus prioritaires et nous cherchons des méthodes pour essayer d'y répondre.

Je vais en rester là, monsieur le président, pour pouvoir répondre à vos questions.

Le président: Merci. Puis-je vous poser une question d'ordre administratif? Avez-vous l'intention de produire un rapport annuel?

M. Millar: Oui, nous sommes décidés à publier un rapport annuel, qui ne sera cependant pas nécessairement aussi biblique que celui-ci. De fait, nous avons l'intention de publier non seulement un rapport annuel mais aussi une série d'autres rapports, au cours de l'année à venir, sur divers aspects du système de santé.

Le président: Nous veillerons à les obtenir lorsqu'ils seront publiés. Pour ce qui est des questions auxquelles vous n'avez pas de réponse, je constate que l'une d'entre elles concerne les listes d'attente. Procédez-vous actuellement à l'élaboration d'une méthode pour recueillir ce type de renseignements?

M. Millar: Oui. De fait, nous avons déjà mis en place un système qui nous permettra d'obtenir des informations standardisées sur la durée de l'attente dans les salles d'urgence. Le système existe déjà et nous nous attendons à avoir des données à ce sujet dès l'an prochain. En ce qui concerne les listes d'attente pour les greffes du cœur, le traitement du cancer, le traitement de la cataracte ou un remplacement de hanche, les données sont plus difficiles à obtenir mais nous tentons de travailler avec les divers groupes professionnels pour y arriver aussi.

Le président: Espérez-vous être en mesure d'obtenir ces renseignements dès l'année prochaine ou beaucoup plus tard?

M. Millar: J'espère que nous les aurons l'année prochaine, à peu près, mais ce sera difficile.

The Chairman: To the layperson, it sounds like it ought to be a no-brainer.

Dr. Millar: It is very difficult. You can read in the report quite a detailed explanation of all the issues around something as straightforward as trying to figure out how long you have to wait to get coronary artery bypass surgery or an angioplasty intervention. You need to define that, first of all. When do you start measuring? Is it when you get your chest pain? Is it when you first see the doctor or a specialist? Do you start it when you first get your catheterization? How do you track all those things? We do not have any databases starting as early as when someone sees the personal physician. The databases in primary care are absolutely and utterly dreadful in this country — as they are in every other country. Bad as it may seem, and despite the amount that we do not know in Canada, we are still ahead of the pack. It is not as if anyone else is doing it a lot better. Australia is doing it better, but it is about the only country that is clearly ahead of us.

The Chairman: We are ahead of the pack because we are a single-payer system.

Dr. Millar: That helps a lot. As well, we do have some big databases. So far, issues like Bill C-6 have not limited the ability to share that data.

The Chairman: We have been through that in this committee, as you know. I should say to senators that all of the overheads that the witness used are in the report, along with a wide variety of others.

We have heard statements that would say roughly the following: Of the amount of health care services provided to an individual, some 30 or 40 or 50 per cent is provided in the last six to twelve months of an individual's life. In other words, the cost of medical care that an individual receives goes up enormously as the individual nears the end of his life. Is there any hard data that gives a number to that?

Dr. Millar: How much is consumed by people over a certain age?

The Chairman: No. Let me tell you where I am headed. People have said that the aging population is one of the big drivers of cost. My question is whether it is the aging of the population or simply the fact that as you increase life expectancy the costs associated with trying to delay death as long as possible in fact inevitably occur at an older age.

In other words, does a healthy 70-year-old put any more drain on the system than a healthy 50-year-old? Conversely, if a 55-year-old has cancer and is dying, is there any reason why the cost of that treatment should be less than the cost of treating a 75-year-old?

Dr. Millar: I would like to rephrase the question in the way I think about it. Clearly, we are living longer. The corollary to that is: Are we living healthier or less healthier? If we are living more healthily, then we could anticipate that the costs would not

Le président: Pour un néophyte, cela semble parfaitement enfantin.

M. Millar: En fait, c'est très difficile. Vous trouverez dans le rapport une explication détaillée de tous les problèmes que peut poser quelque chose d'aussi simple qu'essayer de savoir combien de temps on devra attendre pour un pontage coronarien ou une angioplastie. C'est ce qu'il faut commencer par définir. Quand commence-t-on à mesurer? Quand on commence à avoir des douleurs à la poitrine? Quand on voit le médecin ou le spécialiste pour la première fois? Quand on a le premier cathétérisme? Comment obtenir des données sur toutes ces choses? Nous n'avons pas d'informations générales commençant au moment où le patient voit son médecin personnel. Les bases de données concernant les soins primaires sont absolument pitoyables dans notre pays — comme dans tous les autres, d'ailleurs. Cela dit, aussi insatisfaisant que cela paraisse, et malgré toutes les choses que nous ne savons pas, nous sommes encore en avance sur les autres pays. Ce n'est pas comme si les autres faisaient beaucoup mieux que nous. L'Australie fait mieux mais c'est à peu près le seul pays qui soit clairement en avance sur nous.

Le président: Nous sommes en avance sur les autres parce que nous avons un système à payeur unique.

M. Millar: Cela y contribue beaucoup. En outre, nous avons certaines grosses bases de données. Jusqu'à présent, des questions comme le projet de loi C-6 n'ont pas limité notre attitude à partager ces données.

Le président: Nous avons déjà traité de cette question au sein du comité, comme vous le savez. J'ajoute à l'intention des sénateurs que toutes les acétates présentées par le témoin se trouvent dans le rapport, avec beaucoup d'autres.

On dit parfois que, sur tous les services de santé dispensés à une personne, quelque 30 p. 100, 40 p. 100 ou 50 p. 100 le sont dans les six à 12 derniers mois de sa vie. Autrement dit, le coût des soins médicaux augmente considérablement à mesure que la personne arrive à la fin de sa vie. Existe-t-il des données solides à ce sujet?

M. Millar: Sur le coût des services utilisés par les gens au-delà d'un certain âge?

Le président: Non, je me suis mal expliqué. On dit que le vieillissement de la population est l'un des principaux facteurs de coût. Ma question est de savoir s'il s'agit vraiment du vieillissement de la population ou simplement du fait que l'augmentation de l'espérance de vie entraîne une augmentation des coûts, puisqu'on essaie de retarder la mort le plus possible.

Autrement dit, est-ce qu'une personne de 70 ans en bonne santé exerce plus de demande sur le système qu'une personne de 50 ans en bonne santé? En revanche, si une personne de 55 ans est atteinte du cancer et est sur le point de mourir, y a-t-il une raison quelconque pour que le coût de son traitement soit inférieur à celui du traitement d'une personne de 75 ans?

M. Millar: J'aimerais reformuler votre question pour vous indiquer comment je l'interprète. Il est clair que nous vivons plus longtemps. La corollaire de cette proposition est celle-ci: vivons-nous plus longtemps en meilleure santé ou non? Si nous

necessarily go up as we age. The early demographic findings published fairly recently by Statistics Canada indicate that we are living both longer and more healthily. Therefore, the anticipated impact on the health care system is not necessarily as severe as we once thought it might be.

The Chairman: To get back to my first question, we have heard from some witnesses whose basic thesis is that as someone gets really sick and ultimately dies at the end of that process, they consume a very large amount of medical services in dollar terms in an attempt to delay the end. Do we have any measure of what that costs? I am asking that because it seems to me that, if it is correct that that is a disproportionate amount of the medical services one consumes in a lifetime, then it may be that more than demographics is actually driving the change. That is to say just because people live longer then, by definition, they do not die until a later age. We seem to be focusing entirely on the age of 65, or on the number, rather than the fact that it is simply a reality that always through life, whenever it is time to die, it is that last six months that is really very expensive.

Dr. Millar: I am not aware that anyone has done the projections that we would need to come up with a valid answer. Projecting is a tricky game. Generally, we have avoided putting a lot of effort there.

The Chairman: Is it your feeling, therefore, that some of the bold statements of fact on that issue that we have received should be looked at with some scepticism?

Dr. Millar: Yes. I certainly would.

Senator Carstairs: In looking at what you have provided I have come across two or three charts in which data for Manitoba was not available. Since that is my province, can you tell what the explanation is for that?

Dr. Millar: Could you refer me to a specific chart, senator?

Senator Carstairs: I am sorry, but I cannot.

Dr. Millar: Manitoba is featured quite positively in this report because of the Manitoba Centre on Health Policy and Evaluation, which does superb work and which has provided a great deal of good data.

The Chairman: There is a chart on page 43 headed, "How Babies Are Born." There are only eight provinces listed. You do not have Quebec or Manitoba.

Senator Carstairs: It states that Manitoba data are not available.

Dr. Millar: The reason for that is that Manitoba and Quebec do not participate in one of our databases, which is the discharge abstract database.

The Chairman: Why not?

Dr. Millar: Because they have their own wonderful system, they do not really need us. They have high quality data. However,

vivons en meilleure santé, nous devrions nous attendre à ce que les coûts n'augmentent pas nécessairement avec le vieillissement. Les premières données démographiques publiées assez récemment par Statistique Canada montrent que nous vivons en fait à la fois plus longtemps et en meilleure santé. En conséquence, l'incidence prévisible sur le système de santé ne sera pas nécessairement aussi forte qu'on a pu le penser.

Le président: Pour revenir à ma première question, certains témoins nous ont dit que l'équation fondamentale est celle-ci: quand une personne tombe vraiment malade et finit par mourir, elle consomme une très grosse quantité de services médicaux, en termes monétaires, pour tenter de repousser la fin. Sommes-nous capables de mesurer ce que cela coûte? Je pose la question parce qu'il me semble que, s'il est vrai que cela représente une part disproportionnée des services médicaux que chacun consomme pendant toute sa vie, cela s'explique peut-être par plus que des facteurs démographiques. En effet, si les personnes vivent plus longtemps, il s'ensuit, par définition, qu'elles ne meurent pas avant un âge plus avancé. Nous semblons être totalement focalisés sur l'âge de 65 ans plutôt que sur le fait qu'il y a une réalité tout à fait incontournable qui est que, quel que soit l'âge du décès, ce sont toujours les six derniers mois qui coûtent vraiment très cher.

M. Millar: Je ne sais pas si quelqu'un a fait les projections dont nous aurions besoin pour vous donner une réponse valide. Il est toujours difficile de faire des projections. En général, nous évitons d'y consacrer beaucoup d'effort.

Le président: Avez-vous donc le sentiment que certaines des affirmations très brutales qui nous ont été faites à ce sujet devraient être examinées avec un certain scepticisme?

M. Millar: Certainement.

Le sénateur Carstairs: En examinant votre rapport, j'ai vu deux ou trois graphiques pour lesquels les données relatives au Manitoba sont absentes. Comme c'est ma province, j'aimerais savoir si vous avez une explication à cela?

M. Millar: Pourriez-vous me dire de quel graphique il s'agit, sénateur?

Le sénateur Carstairs: Je regrette, je ne peux pas.

M. Millar: Le Manitoba figure de manière très positive dans ce rapport à cause du Centre d'élaboration et d'évaluation de la politique des soins de santé du Manitoba, qui fait un excellent travail et qui nous a fourni beaucoup d'excellentes données.

Le président: Il y a à la page 43 un graphique intitulé: «How Babies Are Born». On n'y mentionne que huit provinces, c'est-à-dire qu'il n'y a pas le Québec ni le Manitoba.

Le sénateur Carstairs: On y dit aussi que l'on n'a pas de données sur le Manitoba.

M. Millar: La raison en est que le Manitoba et le Québec ne participent pas à l'une de nos bases de données, celle des congés d'hôpitaux.

Le président: Pourquoi?

M. Millar: Parce que ces deux provinces ont leur propre système, qui est excellent. Elles n'ont pas besoin de nous. Elles

there has never been a sharing agreement set up so that we can capture it. It represents higher quality rather than less quality.

Senator Carstairs: That is the point I wish to make. If we are to reform the system, then we have to be willing to share all our information with one another. The fact that they are not included in this — and I knew they had better information, as a matter of fact — disturbs me because there does not seem to be the desire to share.

Dr. Millar: We would welcome any interventions in that area.

Senator Carstairs: I will do what I can. The second last slide is a glimpse inside the system. It has to do with rehabilitation outcomes. I was quite surprised by what I saw. It seemed to me that the improvement in functional status under joint replacement was very small. Yet, we hear constantly, from the elderly in particular, about the constant need of joint replacement.

Dr. Millar: It is an interesting observation. You will notice that this is under rehabilitation services. There are many things you can do for someone who has had a spinal injury and, over the course of time, see big improvements. For someone with an amputation, there is not much that you can do over time. I suppose that is a reflection of the degree to which you can expect to see change. This does not tell you what the expected change is. It just tells you what was achieved. These data were drawn from a pilot study that is beginning to explore the types of outcomes in the area of rehabilitation. It is like an early snapshot.

Senator Keon: I am really pleased to see the first report, which I think is a great beginning. Do you happen to have the flu data province by province? I think there is something very interesting falling out there, at least anecdotally. For example, Alberta boasts that the flu wave hardly affected them because of their regional organization and so forth. Ontario was hit the hardest because there is no regionalization. Do you happen to have graphs for each province?

Dr. Millar: They are available, but we do not have them in that format. They could be looked at, but I have not seen them in that way. They come from LCDC at Health Canada.

Senator Keon: It would be interesting to get them out before next year's epidemic, because this is one loop where we could have feedback almost immediately.

Dr. Millar: Indeed.

Senator Keon: Senator Carstairs referred to the end of your report and the short rehab section that continues on to home care. As the report indicates, this is just a beginning. I have felt for a long time that this is one of the areas that have to be addressed and organized.

ont d'excellentes données. Par contre, il n'y a jamais eu d'accord de partage des informations et nous n'y avons donc pas accès. Je peux cependant vous dire qu'il s'agit de données de qualité supérieure.

Le sénateur Carstairs: C'est précisément ce que je voulais dire. Si nous voulons réformer le système, nous allons devoir accepter de partager toutes nos informations les uns avec les autres. Le fait que nous n'ayons pas les données de ces provinces — et je savais qu'elles étaient meilleures, je le précise — est troublant car cela semble indiquer qu'on ne veut pas les partager.

M. Millar: Nous serions ravis si quelqu'un voulait bien intervenir.

Le sénateur Carstairs: Je verrai ce que je peux faire. L'avant-dernière acétate portait sur les résultats en matière de réadaptation fonctionnelle. J'ai été très surprise de ce que j'y ai vu. J'ai eu l'impression que l'amélioration fonctionnelle en cas de remplacement d'articulations est très minime. Pourtant, on entend dire constamment, surtout chez les personnes âgées, qu'il y a un besoin constant en matière de remplacement d'articulations.

M. Millar: C'est une observation intéressante. Vous constaterez que l'acétate en question touche les services de réadaptation fonctionnelle. Il y a bien des choses que l'on peut faire pour quelqu'un qui a subi un traumatisme médullaire, et l'on peut voir au bout d'un certain temps une nette amélioration. Par contre, pour quelqu'un qui a subi une amputation, il n'y a pas grand-chose qu'on puisse faire à long terme. Je suppose que cela indique dans quelle mesure on peut s'attendre à des changements. Ceci ne vous dit pas quelle est la nature du changement attendu mais seulement quel résultat on a atteint. Ces données sont tirées d'une étude pilote qui a été lancée pour étudier les résultats en matière de réadaptation fonctionnelle. C'est comme s'il s'agissait d'un premier instantané.

Le sénateur Keon: Je suis très heureux de voir ce premier rapport qui constitue à mes yeux un excellent départ. Possédez-vous des informations sur la grippe, province par province? Je pense qu'il se passe des choses très intéressantes à ce sujet, si j'en crois ce qu'on dit. Par exemple, l'Alberta prétend que la vague de grippe l'a à peine touchée du fait de son organisation régionale, entre autres choses. L'Ontario est la province qui a été le plus durement touchée parce qu'il n'y a pas de régionalisation. Possédez-vous des graphiques pour chaque province?

M. Millar: Les données sont disponibles mais pas sous cette forme. Je ne les ai pas encore vues de cette manière. Elles proviennent du LLMC, de Santé Canada.

Le sénateur Keon: Il serait intéressant de les examiner avant l'épidémie de l'an prochain car c'est un domaine pour lequel on peut obtenir des réactions quasi immédiates.

M. Millar: En effet.

Le sénateur Keon: Le sénateur Carstairs a évoqué la fin de votre rapport, qui contient une brève analyse de la réadaptation fonctionnelle et des soins à domicile. Comme vous l'indiquez, c'est un début. J'ai longtemps pensé qu'il s'agit là d'un des domaines méritant plus d'attention.

Do you have in place a mechanism for looking at other countries that have invested a lot in this area? I am thinking in particular of Germany. About 20 years ago, they invested a great deal of money in rehab centres, which they built all over the country. They then found that they had a dysfunctional program from which they could not withdraw people and so forth. In your report you present continuity in terms of home care and rehab, which is terrific. What template are you trying to develop to look at this?

Dr. Millar: When developing indicators, wherever we can we are doing it to conform with international standards, if there are any. It is very easy for things like life expectancy, where there are some standard methodologies. The fact is that for many of these things we are the cutting edge. We are ahead of most other countries, so there are no comparative data. We are just inventing them on our own and hoping others will follow our lead. In fact, that is the strategy we are taking within the country. For example, the cardiac care network in Ontario has set a standard. We are encouraging that to be picked up in other parts of the country.

Senator Keon: How are your links unfolding with provinces like Manitoba and ISIS in Ontario? Are you getting direct links from there or is your information coming in through periodic reports or information-gathering sessions?

Dr. Millar: For most provinces, the links are very direct and they participate fully. We operate 14 databases for expenditures, organ replacement, major trauma, et cetera. There is a number of them. In most of those there is full provincial participation. There is this exception of Manitoba and Quebec for the biggest database, which is the discharge abstract database. By and large, there is very good cooperation with the provinces.

With specific organizations like ISIS, we also have a good working relationship. ISIS draws on our data for many of the research projects they do. Having said that, we are certainly looking for opportunities to develop further partnerships with whoever is interested in better using these data that we hold.

Senator Fairbairn: This looks like a very interesting publication. I am sure many questions were asked by you in terms of building this mechanism to get information.

I am particularly focused on the final part about home care and institutional care. I did notice the headline that everything old is new again with home care in Canada. This is one issue of the new health care system or the new health care reality in Canada that we need to know much more about — not only where it exists but how it works. I guess it exists in every province of Canada. How it is connected to the hospital and the physician is one of the big questions, because sometimes those connections are very shaky, although the program in theory may be good. At this point in time, are you able to make any comparative comments between provinces in Canada, or are you still at the point where you are

Êtes-vous en mesure d'examiner la situation dans les pays qui ont beaucoup investi dans ce secteur? Je songe en particulier à l'Allemagne. Il y a une vingtaine d'années, elle a beaucoup investi dans la construction de centres de réadaptation fonctionnelle dans ses diverses régions, pour constater ensuite qu'elle avait un programme dysfonctionnel dont elle ne pouvait faire sortir les gens. Dans votre rapport, vous parlez de continuité du point de vue des soins à domicile et de la réadaptation, ce qui est excellent. Quelle méthode essayez-vous d'élaborer pour examiner ce domaine?

M. Millar: Chaque fois que nous préparons des indicateurs, nous essayons de le faire en tenant compte des normes internationales, s'il y en a. C'est très facile pour des choses comme l'espérance de vie, qui fait l'objet de méthodologies normalisées. Par contre, dans beaucoup de domaines, nous sommes à l'avant-garde. Nous sommes en avance sur la plupart des autres pays et nous n'avons donc pas de données comparatives. Nous inventons nos propres indicateurs, en espérant que d'autres nous emboîteront le pas. De fait, c'est aussi la stratégie que nous utilisons au Canada même. Par exemple, le réseau de traitement des maladies cardiaques de l'Ontario a établi une norme et nous encourageons les autres provinces à l'adopter.

Le sénateur Keon: Quels sont vos liens avec des provinces comme le Manitoba et avec le SIIS de l'Ontario? Avez-vous établi des liens directs ou recevez-vous des informations à intervalles réguliers, au moyen de rapports ou de sessions d'information?

M. Millar: Pour la plupart des provinces, les liens sont directs et elles participent pleinement. Nous exploitons 14 bases de données concernant les dépenses, les greffes d'organes, les traumatismes graves, et cetera. Dans la plupart des cas, nous bénéficions d'une pleine participation provinciale, à l'exception, comme je l'ai déjà dit, du Manitoba et du Québec, pour ce qui concerne la plus grosse base de données sur les congés des hôpitaux. Dans l'ensemble, la collaboration des provinces est excellente.

Nous avons aussi de bonnes relations de travail avec des organismes comme le SIIS, qui utilise nos données pour bon nombre de ses projets de recherche. Cela dit, nous cherchons continuellement de nouvelles occasions de partenariat avec quiconque souhaiterait faire un meilleur usage des données que nous possédons.

Le sénateur Fairbairn: Votre rapport est très intéressant. Je suis sûr qu'on vous a déjà posé beaucoup de questions au sujet de votre système de collecte de renseignements.

Je voudrais m'intéresser en particulier à la dernière partie du rapport, sur les soins à domicile et les soins en institution. J'ai lu une manchette de journal disant que l'on revient aux anciennes méthodes, en matière de soins à domicile. Il s'agit là d'un domaine de notre nouveau système de santé au sujet duquel nous avons besoin de beaucoup plus d'informations — notamment pour savoir comment il fonctionne. Je suppose qu'il existe de tels services dans chaque province. L'une des grandes questions est de savoir comment ce système est relié aux hôpitaux et aux médecins, car les liens semblent parfois ténus, même si le programme semble théoriquement satisfaisant. Êtes-vous donc en

trying to get that kind of information? Is that information available right now?

Dr. Millar: At the provincial level, you could get comparative data on expenditures on home care and long-term care, but if you want to look at any sort of performance measure, there are none. The good news is that one of the many projects that we have underway is to develop better expenditure data at the regional level so that we can start to get a handle on how much money is going into all the various sectors, including home care and long-term care. Another project is looking at continuity of care indicators. That is one dimension of performance across the system that we are trying to develop, and we are working together with the Canadian Health Services Research Foundation to get some continuity of care indicators. In addition to that, there is a specific project looking at performance indicators in home care and long-term care. In the continuing care side of this, there already are data standards. A private company has developed a minimum data set, and that is now being picked up across the country. We are sort of the mediators for that. That is coming on stream quite quickly.

On the continuing care, the institutional side, I am optimistic that we will have good data that will provide us information on performance on the institutional side of community care. On the home care side, within the scope of the projects we currently are running, we may not have the data, but we will have developed the indicators and the data definitions and can begin the process of having them taken up by the provinces.

Senator Fairbairn: I am sure that we all in this room have had experiences of one kind or another in respect of home care. I have had two — one in Alberta and one here in Ottawa. It struck me that it would be very useful were information available. Some of the gaps in both of those provinces were in totally different areas. People could learn from other people's strengths and weaknesses. Already we are hearing in the study that we have just started that this whole broader definition now of health care being in the home and the community is probably one of our greatest challenges.

Dr. Millar: I agree. It is a major challenge to find the performance, and you must also ask whether someone is being well-helped to move through that system appropriately.

Senator Fairbairn: To find their way through.

Dr. Millar: Yes.

[Translation]

Senator Gill: You said that your Institute had two major objectives: the report on the health of Canadians, and evaluating the performance system. How can your recommendations be implemented? You referred to the standardization of services, in comparison with other countries and among the regions of Canada. How could your recommendations be implemented

mesure de faire des comparaisons entre les provinces ou en êtes-vous seulement au point où vous essayez de recueillir des renseignements valides? Ces renseignements sont-ils déjà disponibles?

M. Millar: Au niveau provincial, on peut obtenir des données comparatives sur les dépenses en matière de soins à domicile et de soins de longue durée mais il n'existe pas de mesure du rendement. De fait, l'un des nombreux projets que nous avons lancés consiste à obtenir de meilleures données sur les dépenses régionales, dans le but de nous faire une bien meilleure idée des sommes qui sont consacrées à chacun des divers secteurs, y compris aux soins à domicile et aux soins de longue durée. Nous avons aussi un autre projet portant sur les indicateurs de continuité des soins. Il s'agit là d'un aspect du rendement du système que nous essayons de mesurer, et nous collaborons avec la Fondation canadienne de la recherche sur les services de santé pour établir des indicateurs sur la continuité des soins. En outre, nous avons un projet consacré uniquement à l'élaboration d'indicateurs de rendement pour les soins à domicile et les soins de longue durée. En ce qui concerne les soins prolongés, il existe déjà des données normalisées. Une société privée a élaboré une série de données minimums qui est en train d'être adoptée dans l'ensemble du pays. Nous jouons le rôle de médiateur, en quelque sorte, à ce sujet, et le projet avance bien.

En ce qui concerne les soins prolongés, c'est-à-dire le volet institutionnel, j'espère que nous pourrions obtenir de bonnes données pour pouvoir mesurer le rendement du côté institutionnel des soins communautaires. Pour ce qui est des soins à domicile, nous n'avons peut-être pas encore les données voulues mais nous avons élaboré des indicateurs et défini les données requises et nous pouvons donc commencer à les faire adopter par les provinces.

Le sénateur Fairbairn: Je suis sûr que nous avons tous eu l'expérience de soins à domicile, sous une forme ou une autre. Pour ma part, j'en ai eu deux: une en Alberta et l'autre ici même, à Ottawa. Je pense qu'il serait très utile d'avoir des informations solides à ce sujet et j'ai été frappée de voir que les lacunes dans ces deux provinces touchaient des domaines totalement différents. Je pense que l'on aurait beaucoup à apprendre des atouts et faiblesses des autres. L'étude que nous avons entreprise nous a déjà montré que toute cette question de définition des soins à domicile et communautaires constituera probablement l'un des plus grands défis à relever.

M. Millar: Je suis d'accord. Il est très difficile de mesurer le rendement et on doit aussi se demander si les gens ont les soins qu'il faut pour passer dans ce système adéquatement.

Le sénateur Fairbairn: Pour en sortir.

M. Millar: Oui.

[Français]

Le sénateur Gill: Vous avez mentionné que votre institut visait deux objectifs importants: le rapport sur la santé des Canadiens et l'évaluation de la performance du système. Quelles applications vos recommandations peuvent-elles avoir? Votre exposé mentionne la standardisation des services en rapport avec les autres pays et avec les régions du Canada. Quelles applications

across the country? Once the recommendations are made at the national level, how do you take geography into account? How and where can your recommendations be implemented?

[English]

Dr. Millar: Our organization is not mandated to make policy recommendations. Our mandate is to provide the very best possible information to put into the hands of policymakers so that they can use the information to develop policy. Our task is to get the best information, but not to make policy recommendations.

How do we envision the data being used to be relevant both internationally and between regions? We envision that the data is being provided to the governors of the system — ministries of health, regional health authorities and so forth — and also to the provider groups and the managers in the system, and also directly to the public. We are targeting this data at several different parts of society.

For the managers and governors in the system, the intent is to support the development of better policies. For the health care system providers, this is clearly intended to support improved quality of service, the continuous quality improvement of service. A very practical example of that would be the C-section rate. For example, the C-section rate in Victoria, B.C., is 24 per cent. That has already stimulated people to pay more attention. They would go to one of the jurisdictions in Saskatchewan or Quebec that is down around 13 or 15 per cent and say to them, "Well, how did you do it? How did you get your rate cut in half like that?" It is to provide that ability to improve quality. Then, by getting this data into the hands of the public directly, we believe that with a better informed public you get, in fact, better governance, ultimately, and better accountability for what the public is getting for its money.

Those are the ways in which we are disseminating this information into various sectors to have its impact, but, again, not making direct policy recommendations.

[Translation]

Senator Gill: Do you have any data about Aboriginals and, if so, how did you get it? Who do you deal with at the national level?

[English]

Dr. Millar: The question of aboriginal health is very difficult. We do have data on health status, how healthy they are, and we know they are much worse off, although the gap between aboriginal and non-aboriginal is improving. There are generally improvements in both sectors. There still continues to be a huge gap, and it is the most egregious gap in the country. Aside from that, we have very little data. For example, when First Nations people go into hospital, their status is not recorded on the data, so we have no way of tracking that. We do not have any routine way of discovering what level of services they are getting or the outcomes related to that service. Any data available is mostly

vos recommandations peuvent-elles avoir à la grandeur du pays? Est-ce qu'on tient compte, une fois que ces recommandations sont faites au plan national, de la géographie dans cette application? Comment et où l'application se fait-elle suite à vos recommandations?

[Traduction]

M. Millar: Nous n'avons pas pour mandat de faire des recommandations sur les politiques. Notre rôle consiste simplement à mettre à la disposition des décideurs les meilleures informations possibles, car ce sont eux qui formulent les politiques. Notre tâche est d'obtenir les meilleures informations, pas de recommander des politiques.

Comment pensons-nous que les données doivent être utilisées pour être pertinentes au palier international et entre les régions? Nous envisageons que les données soient fournies aux gouverneurs du système — les ministères de la Santé, les autorités régionales de la santé, et cetera — ainsi qu'aux groupes qui dispensent les soins, aux gestionnaires du système et, directement, au public. Ces données sont donc destinées à plusieurs parties différentes de la société.

En ce qui concerne les gestionnaires et les gouverneurs du système, l'objectif est qu'ils s'en servent pour formuler de meilleures politiques. Pour ce qui est de ceux qui dispensent les soins, nous souhaitons à l'évidence qu'ils s'en servent pour améliorer continuellement la qualité des soins. Nous en avons un exemple très concret avec les césariennes. À Victoria, par exemple, la proportion de césariennes est de 24 p. 100. Cela a déjà retenu l'attention de certaines personnes. En constatant le taux en Saskatchewan ou au Québec, qui est de 13 p. 100 ou 15 p. 100, elles se sont demandé comment ces provinces ont réussi à réduire le taux de moitié. Notre rôle est donc de produire des données permettant d'améliorer la qualité. Ensuite, en communiquant ces données directement au public, nous pensons qu'il sera mieux informé, ce qui débouchera sur une meilleure gouvernance car le public pourra mieux juger la manière dont on utilise son argent.

Voilà donc comment nous diffusons les renseignements dans les divers secteurs de la société mais, je le répète, nous ne formulons pas de recommandations en matière de politiques.

[Français]

Le sénateur Gill: Avez-vous des données concernant les autochtones et si oui, comment les obtenez-vous? Avec qui transigez-vous au plan national?

[Traduction]

M. Millar: Les soins dispensés aux Autochtones posent une question très difficile. Nous possédons des données sur la santé des Autochtones et nous savons qu'elle est beaucoup moins bonne que chez les non-autochtones, bien que l'écart ait tendance à rétrécir. La situation s'améliore des deux côtés. Certes, il y a encore une différence énorme et c'est insupportable. Cela dit, nous possédons très peu de données concrètes. Par exemple, lorsqu'un Autochtone est hospitalisé, son statut d'autochtone n'est pas enregistré. Nous n'avons donc pas la possibilité de mesurer la qualité des services dispensés aux autochtones, ni les résultats de ces services. Les données dont on dispose proviennent

done on the basis of surveys. There have been some recent aboriginal health surveys. The best available information is in some Health Canada publications that have recently come out. If you refer to those, I think you will find that that is as good as it gets. We have very little in our database that can help shed light on that.

That being said, there is one area where we can help. Although we cannot identify specific aboriginal people within communities, there are communities in the country where they are largely aboriginal folk: Northwest Territories, Yukon, Nunavut, northern areas of Manitoba and so forth, Saskatchewan, B.C. and Quebec.

We can do small numbers analyses in those areas and provide the same type of data by region, as you see in the back of the document, and then go down to smaller regions. We can provide this type of array of data, which gives some sense, then, of how those largely aboriginal communities are being served and the outcomes related thereto. That is an area on which we are moving ahead.

The point I am making is that that will not be specifically aboriginal; nor will it be able to split out Métis from Innu or Haida.

Senator Fairbairn: Would it be the case, then, that in any given hospital you would not have a picture of the clientele of that hospital, whether it be aboriginal or people from other backgrounds? In other words, is there any way in which we can define that hospital population?

Dr. Millar: There is only one database that we have in which ethnic information is entered. That is the Canadian Organ Replacement Register. That captures, for example, aboriginals, Vietnamese or whatever you want. Aside from that one database, hospital databases do not record that. That has been at the wish of the ethnic groups themselves, who do not want to be identified.

The Chairman: You said earlier that, overall, lower-income people have a lower quality of health. You also said that lower educated people and rural people have lower quality of health. We recognize that the vast majority of aboriginal people in your database would be low income and rural. Therefore, even if they were not aboriginal, they would not have as good a health record as the average Canadian. Can you adjust your data to understand how much, beyond the fact that they are low income and rural, owes to the fact that they are aboriginal? In other words, I am trying to understand if you can isolate the aboriginal parameter alone or if the aboriginal data is in part because they are aboriginal and in part because they are low income and rural?

Dr. Millar: I can answer that question from the literature in broad terms. We know that racial or genetic factors on a population basis have a very small amount of explanatory power in explaining these differences. The Japanese are the healthiest

essentiellement d'enquêtes. On a récemment effectué des enquêtes spéciales sur la santé des Autochtones et les meilleures informations disponibles à ce sujet se trouvent dans certaines publications récentes de Santé Canada. Vous y trouverez les meilleures informations disponibles à ce sujet. Notre propre base de données est fort peu utile à cet égard.

Cela dit, il y a un domaine dans lequel nous pouvons être utiles. Même si nous ne pouvons pas identifier les Autochtones dans chaque collectivité, il y a certaines collectivités qui sont en grande majorité composées d'Autochtones, dans les Territoires du Nord-Ouest, au Yukon, au Nunavut, ainsi qu'au nord du Manitoba, de la Saskatchewan, de la Colombie-Britannique et du Québec.

Nous pouvons analyser les chiffres concernant ces provinces, comme vous pouvez le voir à la fin du document, puis produire des données pour des régions plus petites. De cette manière, nous pouvons savoir quels services sont dispensés dans ces collectivités essentiellement autochtones et quels sont les résultats. C'est un domaine dans lequel nous avançons.

Je précise toutefois que ces données ne permettent pas de faire la distinction entre les divers groupes d'autochtones, comme les Métis, les Inuits ou les Haidas.

Le sénateur Fairbairn: Est-il donc possible de dire que vous n'avez pas de données précises sur la clientèle de chaque hôpital, c'est-à-dire sur l'origine ethnique des patients? Autrement dit, y a-t-il moyen de cerner la composition ethnique des patients?

M. Millar: Il n'existe qu'une seule base de données à caractère ethnique, c'est le Registre canadien des insuffisances et des transplantations d'organes, qui contient des informations, par exemple, sur les autochtones, les Vietnamiens, et cetera. À part cela, les informations ethniques ne sont pas enregistrées dans les bases de données des hôpitaux et je précise que c'est à la demande des groupes ethniques eux-mêmes, qui ne veulent pas être identifiés de cette manière.

Le président: Vous disiez plus tôt que les personnes à faibles revenus ont un niveau de santé inférieur, ce qui est aussi le cas des personnes ayant fait moins d'études et des ruraux. Nous savons que la plupart des autochtones figurant dans votre base de données sont des personnes à faibles revenus et de régions rurales. En conséquence, même s'il ne s'agissait pas d'autochtones, leur niveau de santé ne serait pas aussi bon que celui du Canadien moyen. Pourriez-vous ajuster vos données de façon à comprendre, au-delà du fait qu'il s'agit de personnes à faibles revenus et de régions rurales, la part de ce phénomène qui s'explique par leur caractère autochtone? Autrement dit, seriez-vous en mesure d'isoler le paramètre autochtone ou doit-on considérer que le moins bon état de santé s'explique autant par le fait qu'ils sont autochtones que par le fait qu'ils ont des revenus moindres et qu'ils vivent dans des régions rurales?

M. Millar: Je peux répondre à cette question en me fondant sur les études déjà publiées. Nous savons que les facteurs raciaux ou génétiques ont fort peu à voir pour expliquer ces différences. Les Japonais ont la meilleure santé au monde, et c'est le cas depuis

people in the world and have been for 25 years, in terms of life expectancy. However, when Japanese move to another country, like Hawaii or California, then, by and large, they take on the same mortality patterns as the country in which they live. The aboriginal data all point the same way. This is not a question of being aboriginal. It is a question of having low income, low education, low employment and systematic exclusion from opportunity.

The Chairman: What about the fact that they live in rural areas?

Dr. Millar: The same thing applies in downtown Toronto or downtown Vancouver.

The Chairman: The data one talks about is aboriginal data because for various public policy reasons Canada has a different responsibility for aboriginal health. In fact, it is really a commentary on education, on income and a variety of other things for which we happen to have one particularly identifiable subgroup. Is that fair?

Dr. Millar: I absolutely agree with that.

The Chairman: I thought that would provoke a rebuttal from Senator Gill.

Senator Gill: How do you explain the huge increase in diabetes among aboriginal people? If it is not cultural, how do you explain it?

Dr. Millar: There are wrinkles in this story. I said that there are some small explanatory powers. It is not as if it does not have any. The first time I discovered this was when I was a medical officer in Prince George, B.C. I arrived on the job and found that they had a 50 per cent higher death rate. Immediately, when that hit the papers, everyone thought it was because of the pulp mills or that they drank too much. In fact, what we found is that they die more of heart disease, of cancer, of respiratory disease, of diabetes, of suicide, of homicide, of motor vehicle accidents — more of everything. The pattern that has been shown time and time again is that, where you have a population of people dying more, they are dying more of everything. That is because they are simply more susceptible to getting sick and dying from whatever happens to be around. It is not to say that genetics is totally irrelevant. It does come into play. However, the powerful drivers are those things that make people more susceptible to disease. Those are related more to income, education, jobs, early childhood care, community cohesiveness, and so forth.

Senator Cohen: I have a question about immunization in Winnipeg and the successful results of cutting down emergency room delays. How is that information disseminated across the country, for example, to New Brunswick? The answer may be similar to the C-section answer. Is this report the first issue?

Dr. Millar: Yes. The Manitoba Centre for Health Policy and Evaluation routinely produces reports as well. The underlying information that led to the policy developments in Winnipeg had

25 ans, du point de vue de l'espérance de vie. Toutefois, lorsqu'ils déménagent dans un autre pays, comme à Hawaï ou en Californie, ils reflètent les mêmes tendances de mortalité que leur nouveau pays. C'est la même chose avec les données concernant les autochtones. La question n'est pas qu'il s'agit d'autochtones mais plutôt de gens qui ont peu de revenus, peu d'éducation et peu de possibilités d'emploi, et qui souffrent d'une exclusion systématique dans ces domaines.

Le président: Qu'en est-il du fait qu'ils vivent dans des régions rurales?

M. Millar: La même chose vaut pour Toronto ou Vancouver.

Le président: Les données dont nous parlons concernent les Autochtones parce que, pour diverses raisons de politique publique, le Canada assume une responsabilité différente en matière de santé des autochtones. Cela dit, elles représentent en fait une critique sur l'éducation, les revenus et beaucoup d'autres choses concernant un sous-groupe particulièrement identifiable, n'est-ce pas?

M. Millar: Je suis tout à fait d'accord avec vous.

Le président: Je pensais que cela susciterait une réfutation de la part du sénateur Gill.

Le sénateur Gill: Comment expliquez-vous l'énorme augmentation du diabète chez les autochtones? Si ce n'est pas culturel, comment l'expliquez-vous?

M. Millar: Il y a sans doute d'autres facteurs en cause. J'ai dit tout à l'heure que ces données n'expliquent pas tout. La première fois que j'ai découvert cela, c'était dans mon rôle d'agent médical à Prince George, en Colombie-Britannique. En arrivant là-bas, j'ai constaté que le taux de décès était de 50 p. 100 plus élevé. Dès que cela a été publié dans les journaux, tout le monde a pensé que c'était à cause des usines de pâtes et papiers ou d'une consommation excessive d'alcool. En fait, ce que nous avons constaté, c'était qu'ils mourraient plus de troubles cardiaques, de cancer, de maladies respiratoires, de diabète, de suicide, d'homicide, d'accidents de la route — c'est-à-dire de bien d'autres choses. Toutes les études ont montré que, lorsqu'on a une population où il y a plus de morts, ils meurent plus de tout. C'est simplement parce que les gens sont plus susceptibles de tomber malades et de mourir à cause de tout ce qui arrive autour d'eux. Ça ne veut pas dire que les facteurs génétiques n'ont strictement rien à voir mais que les facteurs les plus puissants sont reliés aux choses qui rendent les gens plus susceptibles de maladie. Il s'agit donc plus d'une question de revenus, d'éducation, d'emploi, de soins pendant la petite enfance, de cohésion de la communauté, et cetera.

Le sénateur Cohen: Je voudrais poser une question au sujet de l'immunisation à Winnipeg et de l'effet que cela a pu avoir sur la réduction des périodes d'attente dans les salles d'urgence. Comment cette information est-elle diffusée dans le reste du pays, par exemple au Nouveau-Brunswick? La réponse est peut-être la même que pour les césariennes. Ce rapport est-il le premier?

M. Millar: Oui. Le Centre d'élaboration et d'évaluation de la politique des soins de santé du Manitoba produit également des rapports à intervalles réguliers. Les informations qui ont amené à

already been published. It does not get huge media attention. This is an attempt to add to the dissemination of that type of knowledge.

Senator Cohen: Wouldn't a simple solution be to immunize the people, and thus have less of a back up?

When Dr. Fraser Mustard visited us a few months ago, he said that a lot of the diseases of old can be traced back to the first five or six years of a person's life. Have you done any studies on that in conjunction with this report? Where did he get his statistics? It seems that we are very advanced in our medical knowledge, but in our information gathering and data we are almost primitive.

Dr. Millar: You have to understand that this report is an attempt to get standardized comparable data in every region across the country. That is a far different thing. Dr. Mustard's work is all based on research studies — small, intense gatherings of data for a very specific academic purpose.

Senator Cohen: That could impact on health.

Dr. Millar: That is right. To answer your question whether we are doing anything in this area, we certainly are. CIHI received \$95 million from the federal government a year ago, February, for three major projects. One of those, which will account for \$20 million, is the Canadian Population Health Initiative. That is doing further research work in particular in the area of population health. One of the areas that will be researched is that early childhood piece.

One thing I should mention is the fact that at the moment, amongst all the indicators that we are trying to track in here, we do not have one for early childhood. We cannot say how well children are doing, region by region in the country. There has been an indicator developed at McMaster. It has been piloted now. One of the places in which it was piloted was Winnipeg. It is showing some results. Fraser Mustard has been part of that as well.

We are working with HRDC, McMaster, Statistics Canada and the Conference of Ministers of Education across the country to see if we cannot get that in place. It is used when children hit kindergarten. It can be done by the kindergarten teacher. It is not used as an individual way of identifying problem children. It surveys the whole class of kindergarten kids and captures how well they are doing in their ability to read and recognize words, and it tracks their numbers abilities, their social behaviours, their classroom behaviours and their emotional development.

It captures an array of about five or six dimensions and gives you a snapshot of how well the kids are doing at a given community. It relates that to the availability of things like qualified day care and various things. There is a community mapping piece that goes with it. It is very cost effective. We could assess every child in the country for as little as \$4 million. This is something that we are trying to actively get in place as quickly as we can so that we can capture that very important dimension.

modifier les politiques à Winnipeg avaient déjà été publiées. Cela ne suscite pas beaucoup d'intérêt dans la presse. Nous nous efforçons de diffuser le mieux possible ce type d'information.

Le sénateur Cohen: Est-ce qu'il ne serait pas plus simple d'immuniser les gens pour avoir moins de monde dans les salles d'urgence?

Lorsque le Dr Fraser Mustard est venu témoigner, il y a quelques mois, il nous a dit que bon nombre des anciennes maladies pouvaient être retracées aux cinq ou six premières années de la vie. Avez-vous étudié cela dans le cadre de ce rapport? D'où provenaient ses statistiques? Il me semble que nous avons fait beaucoup de progrès dans nos connaissances médicales mais que notre collecte de données reste presque primitive.

M. Millar: Vous devez comprendre que ce rapport est une tentative d'obtention de données comparables normalisées pour chaque région du pays. C'est bien différent de ce que fait le Dr Mustard, qui repose sur des recherches ponctuelles — c'est-à-dire la collecte intensive de données très précises dans un but de recherche très particulier.

Le sénateur Cohen: Cela pourrait avoir une incidence sur la santé.

M. Millar: C'est juste. Pour répondre à votre question, nous faisons certainement des études dans ce domaine. L'ICIS a reçu 95 millions de dollars du gouvernement fédéral, il y aura un an en février, pour trois grands projets. L'un d'entre eux, de 20 millions de dollars, est l'Initiative sur la santé de la population canadienne dont l'un des éléments consistera précisément à faire des recherches sur la petite enfance.

Je dois d'ailleurs préciser que, parmi tous les indicateurs que nous essayons de suivre, il n'en a pas, pour le moment, sur la petite enfance. Nous ne pouvons pas dire quelle est la situation des enfants, région par région. Un indicateur a été mis au point à McMaster et fait actuellement l'objet d'un projet pilote, notamment à Winnipeg. Il produit déjà des résultats. Fraser Mustard y a aussi participé.

Nous collaborons avec DRHC, McMaster, Statistique Canada et la Conférence des ministres de l'Éducation pour voir si nous pourrions mettre cela en place. C'est utilisé lorsque les enfants arrivent au jardin d'enfance. C'est l'enseignant du jardin d'enfance qui peut s'en servir. On ne l'utilise pas comme mécanisme individuel pour identifier les enfants à problèmes mais plutôt pour évaluer des classes complètes et voir quelles sont les capacités des enfants en matière de lecture et de calcul, et quel est leur comportement social, leur comportement en classe et leur développement émotionnel.

Il s'agit de mesurer cinq ou six caractéristiques pour faire le point sur les enfants d'une collectivité donnée. C'est relié aux services disponibles, par exemple à des services agréés de garde d'enfants. Il y a avec cela un élément de cartographie communautaire. C'est un système très efficace. Nous pourrions évaluer chaque enfant du pays pour aussi peu que 4 millions de dollars. C'est quelque chose que nous essayons activement de mettre en oeuvre, le plus vite possible, afin de mesurer cet aspect très important des choses.

Senator Cohen: This would also give us a snapshot of the low-income population and what the results can be when you do not have access to healthy eating and life-style. That sounds interesting. It will be very informative for those of us who are not in that profession, such as myself.

The Chairman: Dr. Miller, your last answer says to me that there is a lot to be said for putting much more money in prevention rather than cure, and prevention starting at a very young age. Is that a reasonable conclusion?

Dr. Millar: It is, certainly in the area of early childhood. The data has been well examined, and repeatedly examined. The business case on this is very solid. The number that springs to mind is that every dollar invested in good early childhood care saves about \$7 in the public sector over the subsequent 20 years. It saves in terms of health care costs, justice system costs, and so forth.

Senator Fairbairn: I am very glad that you gave us a vehicle to get that answer. I was going to ask how, if at all, you were able to factor a literacy component into any of your statistics.

What you have said on the early childhood side is critical. This committee has already heard one of our presenters comment on the other end of the scale, which of course can show you how the cost escalates. With our senior citizens, we can have up to 65 per cent having difficulty, for a variety of reasons, including skills, being able to read and understand prescriptions and medical advice. Anecdotally, the Canadian Public Health Association is considering this a distinctive enough problem that they are devoting their national meeting this year, a few weeks from now here in Ottawa, to how literacy levels affect every level in our society.

The early childhood effort will give us a tremendous benefit and is much easier to do than when you get up into other age groups. Do you suppose there is a way that you can find mechanisms to measure against literacy skills, against learning skills, in adults?

Dr. Millar: Literacy is a tricky area, and I am not an expert in literacy measures. You probably know that, if you look at international comparisons, it says that 98 per cent of Canadians are literate, or 99 per cent — a huge number, but we know that that is not addressing the issue of functional literacy.

Senator Fairbairn: Then over 40 per cent have problems.

Dr. Millar: To get data on that by region requires surveys that are quite labour-intensive to administer, I understand. The other major endeavour, as part of this present project, is with Statistics Canada. They have \$40 million of the \$95 million. A good deal of that money is going into the Canadian community health survey. That will capture many things of interest, like smoking rates and diet and obesity and physical activity, but it will not capture literacy because of the difficulties of capturing that in a short survey instrument. It remains problematic. I am personally not aware of anything on the horizon that will do that in a systematic

Le sénateur Cohen: Cela donnerait aussi un instantané de la population à faibles revenus et de ce que peuvent être les résultats quand on n'a pas accès à une bonne alimentation et à un mode de vie sain. Cela semble intéressant. Ce sera très utile pour ceux d'entre nous qui ne faisons pas partie de cette profession, ce qui est mon cas.

Le président: Docteur Millar, votre dernière réponse me dit que l'on aurait beaucoup à gagner à consacrer beaucoup plus d'argent à la prévention plutôt qu'à la guérison, et que la prévention commence à un très jeune âge. Ai-je raison?

M. Millar: Absolument. Il faut commencer dans la toute petite enfance. Les données ne cessent de le confirmer. Les arguments à ce sujet sont très solides. Le chiffre qui me vient à l'esprit est que chaque dollar investi pour assurer de bons soins dans la petite enfance permet d'économiser environ 7 \$ de deniers publics au cours des 20 années qui suivent. Ce sont des économies réalisées en matière de soins de santé, de dépenses judiciaires, et cetera.

Le sénateur Fairbairn: Je suis très heureuse que vous nous ayez donné le moyen d'obtenir cette réponse. J'allais vous demander si l'on pouvait inclure un facteur d'alphabétisation dans vos statistiques.

Ce que vous dites de la petite enfance est crucial. Notre comité a déjà entendu un témoin analyser l'autre partie de l'équation, en nous montrant comment les dépenses peuvent augmenter. Il peut y avoir jusqu'à 65 p. 100 des personnes âgées qui ont du mal, pour toutes sortes de raisons, à lire les ordonnances et à comprendre les recommandations des médecins. L'Association canadienne de santé publique estime que c'est là un problème assez important pour consacrer son assemblée nationale de cette année, qui se tiendra dans quelques semaines à Ottawa, à la manière dont les niveaux d'alphabétisation influent sur chaque secteur de la société.

L'effort consacré à la petite enfance sera extrêmement bénéfique, et les études sont beaucoup plus faciles à faire que pour les autres groupes d'âge. Pensez-vous qu'il serait possible de mesurer les taux d'alphabétisation ou les compétences en apprentissage des adultes?

M. Millar: L'alphabétisation est une question difficile et je ne suis pas expert en la matière. Vous savez probablement que, selon les comparaisons internationales, le taux d'alphabétisation des Canadiens est de 98 p. 100 ou de 99 p. 100 — ce qui est un chiffre énorme mais qui ne nous dit pas grand-chose sur l'alphabétisation fonctionnelle.

Le sénateur Fairbairn: Plus de 40 p. 100 ont des problèmes.

M. Millar: Pour obtenir ces données sur une base régionale, il faudrait faire des enquêtes qui exigeraient beaucoup de personnel, si j'ai bien compris. L'autre activité importante, dans le cadre du projet actuel, est réalisée par Statistique Canada. On y consacre 40 millions de dollars sur les 95 millions. Une bonne partie de la somme est consacrée à une enquête sur la santé communautaire au Canada. On examinera de nombreuses choses intéressantes comme le tabagisme, l'alimentation, l'obésité et l'activité physique, mais on ne pourra pas en profiter pour étudier l'alphabétisation car ce serait difficile à faire avec un tel

comparable way across the country, but I may not know about everything that is going on.

Senator Fairbairn: Starting at the beginning is the best way that we can solve the problem.

Dr. Millar: We could get it at least at the kindergarten level, which I agree is a perfectly reasonable place to start.

The Chairman: Going back to your opening slide, you talked about Canadians spending less than some other countries per capita and nevertheless being healthier. Is it a reasonable conclusion from that, and from some of the other data in the CIHI report, that it is difficult to draw a direct correlation between increased funding for health care and the increased health of Canadians?

I ask that because federal and provincial governments of all stripes get huge publicity by announcing an extra billion or million or whatever for health care. I think the average citizen reading that headline says that is a good thing because the health care system will be better and therefore Canadians will be healthier. Your data leads me to suggest that that conclusion is not obvious. It is certainly not obvious that, if you put \$2 billion more in, you would get twice as much improvement as if you were to put \$1 billion in. Is that true?

Dr. Millar: It is true to say it is complex. You must be careful to define what it is you hope to achieve. I think that is the key here. It probably would not change much in terms of life expectancy, because we are already at a very high level of that. Dumping more money into the system is not really meant to do that. We are really meant to be providing services that people need to achieve better health measured by other means than life expectancy. If people are getting a hip replacement and they are pain free and can function better, then they are healthier, but we do not capture that by life expectancy. I think a large part of the drive for more funding is to provide better services that do in fact often make people healthier.

The Chairman: Better and faster.

Dr. Millar: Yes. The flip side of this is the point I made earlier about why it is such a political issue and why it is so important that it be addressed politically. The more money that goes into the health care sector, and as you know that is now up to 40 per cent of some provincial government budgets, the less that is available for other things like early childhood care. There is always that balance that one has to trade off, and that is very important.

The Chairman: In light of what you said in response to Senator Cohen, investment not in health care but in something else may in fact in the long run have a bigger impact on health care than the direct investment in health care.

instrument d'enquête. Cela reste problématique. Personnellement, je ne connais rien qui soit prévu à ce sujet au Canada, de manière systématique, mais je ne suis pas non plus nécessairement au courant de tout ce qui se fait.

Le sénateur Fairbairn: C'est en commençant au début qu'on a le plus de chance de résoudre le problème.

M. Millar: On peut au moins faire des études au niveau du jardin d'enfants, et je conviens que c'est un point de départ parfaitement raisonnable.

Le président: Au sujet de votre première acétate, vous disiez que les Canadiens dépensent moins par habitant que d'autres pays mais qu'ils n'ont jamais été en meilleure santé. Doit-on conclure de cela et des autres données figurant dans le rapport de l'ICIS qu'il est difficile de faire une corrélation directe entre la hausse des budgets de la santé et l'amélioration de la santé de la population?

Je pose cette question parce que tous les gouvernements, fédéral et provinciaux, se font une publicité monumentale lorsqu'ils annoncent 1 milliard ou 1 million de plus pour la santé. En apprenant cela, le Canadien moyen pense que c'est une bonne chose parce que le système de santé sera meilleur et que la population sera donc en meilleure santé. Vos données me portent à croire que cette conclusion n'est pas nécessairement vraie. Il n'est certainement pas évident que dépenser 2 milliards de dollars de plus produira deux fois plus de bienfaits qu'un milliard, n'est-ce-pas?

M. Millar: Disons que la chose est complexe. Il faut définir les objectifs avec prudence. Je pense que c'est cela qui est crucial. Cette hausse des dépenses ne changerait probablement pas grand-chose du point de vue de l'espérance de vie puisque nous sommes déjà à un niveau très élevé. Jeter plus d'argent dans le système ne vise pas vraiment cet objectif. Ce qu'il faut, c'est fournir les services dont les gens ont besoin pour être en meilleure santé, selon d'autres critères que l'espérance de vie. Quand une personne se fait remplacer l'articulation de la hanche pour ne plus avoir de douleur et pour pouvoir mieux marcher, elle est en meilleure santé mais cela ne change pas son espérance de vie. À mon avis, quand on demande d'augmenter les budgets de la santé, c'est en grande mesure pour obtenir les meilleurs services qui permettent souvent aux gens de se sentir en meilleure santé.

Le président: Meilleurs et plus rapides.

M. Millar: Oui. Le revers de cette médaille est la question que je posais plus tôt en demandant pourquoi c'est une question à caractère tellement politique et pourquoi il est tellement important de l'aborder au niveau politique. Plus on consacre d'argent au secteur de la santé, et vous savez que celui-ci représente aujourd'hui jusqu'à 40 p. 100 du budget de certaines provinces, moins on a d'argent pour d'autres choses comme les soins à la petite enfance. Il y a donc toujours un compromis à faire entre tous les besoins.

Le président: Considérant ce que vous avez dit en réponse au sénateur Cohen, il se peut fort bien que consacrer plus d'argent à d'autres choses qu'au secteur de la santé risque d'avoir en fait une plus grande incidence sur la santé, à long terme, qu'un investissement direct dans ce secteur.

Dr. Millar: Precisely.

The Chairman: Thank you for attending today. Will you please tell your colleagues at CIHI that, as they get various reports, not only would we want them circulated to the committee, but as long as we are in the process of doing this study we would like them to come to the committee and take us through them?

Dr. Millar: Certainly.

The Chairman: Senators, our next two witnesses are Professor Margaret Somerville from McGill and Professor Laura Shanner from the University of Alberta.

Welcome, and please proceed.

Ms Margaret Somerville, Professor, McGill University: Thank you, senator. I have submitted two papers to the committee. One is an article entitled, "The ethics and law of access to new cancer treatments," which deals with the access issues at an individual level. I have also submitted a draft of a chapter — and I will do a bit of advertising here — from a forthcoming book that I have called, *The Ethical Canary*. There are two chapters in that on health care allocation, access, and ethics resources issues.

I would now like to make a few pointed remarks.

The first point to make — and it is one that Professor Shanner will expand on — is that ethics is not simply a matter of good conscience. That is essential, and we have to make sure we have it, but it is much more than that. It is a structured analysis in which we look for the values, and when we have conflicting values, we try to justify the choices we make. That is really what we have to do in limiting health care resources ethically. We have a situation of enormous complexity, and, unfortunately, enormous, unavoidable conflict. I want to speak at an even larger level than the previous witness, than just the health care system itself. I want to speak at the societal level, because in what we can call post-modern, secular, pluralistic, multicultural, western democracies — all adjectives that apply to Canada — we think that health care is the most important societal institution in value carrying, formation, and promotion — and, if it does not do those things well, value destruction — for the society.

There are many reasons why we have great difficulties in dealing with medicare, but I should like to discuss one in particular. I think Canada is probably the strongest example in the world of this. I come from Australia, so I am relatively familiar with their system, which is not dissimilar to ours, but the fact that Canada has always placed such a strong emphasis on a publicly administered, egalitarian system, and that there has been largely, to put it at its mildest, an inhibition of private health care, makes it even more important in terms of those values or functions at the societal level as a whole. Therefore, whatever we do, we are not just thinking about, does some person or some population get

M. Millar: Précisément.

Le président: Je vous remercie d'être venu témoigner aujourd'hui. Pourriez-vous dire à vos collègues de l'ICIS que nous aimerions non seulement qu'ils envoient des exemplaires de leurs divers rapports au comité mais, tant que notre étude ne sera pas terminée, que nous aimerions aussi qu'ils viennent nous les présenter?

M. Millar: Certainement.

Le président: Les deux prochains témoins sont la professeure Margaret Somerville, de McGill, et la professeure Laura Shanner, de l'Université de l'Alberta.

Vous avez la parole.

Mme Margaret Somerville, professeure, Université McGill: Merci, sénateur. J'ai envoyé deux documents au comité. Le premier est un article intitulé «The ethics and law of access to new cancer treatments», qui traite des questions d'accès au niveau individuel. Le deuxième est l'ébauche d'un chapitre — et je vais en profiter pour faire un peu de publicité — de mon prochain ouvrage que j'ai intitulé: *The Ethical Canary*. Il y aura en fait dans cet ouvrage deux chapitres concernant la répartition des services de santé, des questions d'accès aux soins et des questions d'éthique.

Je vais maintenant faire quelques remarques liminaires.

La première — et Mme Shanner y reviendra en détail — est que l'éthique n'est pas qu'une question de conscience. Certes, c'est un aspect essentiel, et nous devons tous veiller à agir avec conscience, mais c'est aussi beaucoup plus que ça. C'est une analyse structurée que l'on entreprend pour fixer des valeurs et, quand on constate que certaines valeurs sont contradictoires, on essaie de justifier les choix que l'on fait. Voilà en fait ce que nous devons faire pour limiter les ressources de santé de manière éthique. La situation actuelle est extrêmement complexe et suscite malheureusement un conflit énorme et inévitable. Je voudrais aborder la question à un niveau encore plus élevé que le témoin précédent, c'est-à-dire en allant au-delà même du système de santé. Je veux me placer du point de vue de la société dans son ensemble car, dans ce que nous pouvons appeler les démocraties occidentales postmodernes, séculières, pluralistes et multiculturelles — adjectifs qui s'appliquent tous au Canada — nous pensons que la santé est l'institution la plus importante dans le cadre de la formation, de la promotion et de l'application des valeurs — et, si cela ne se fait pas bien, de la destruction des valeurs — pour la société.

De nombreuses raisons expliquent pourquoi nous faisons face à de sérieuses difficultés en matière de services de santé mais j'aimerais me concentrer sur l'une d'elles en particulier. Je pense en effet que le Canada en est probablement le meilleur exemple au monde. Comme je viens de l'Australie, je connais relativement bien le système de ce pays, qui n'est pas très différent du nôtre, mais le fait que le Canada ait toujours accordé une importance considérable à un système de santé public et égalitaire, et le fait que cela ait généralement, c'est le moins que l'on puisse dire, inhibé les services de santé privés, en fait un élément encore plus important du point de vue de ces valeurs ou fonctions au niveau

better health care? We are really thinking about, when we make those decisions, what are we doing at that values level?

Health care is so important because, whereas in the past, most of our communities created what you can call their "cultural-societal paradigm," which is really just a shared story that we all buy into, mainly through religion, in our kinds of societies, we have to create it through a secular institution. We usually create it through an institution that carries a value of caring for each other, because caring for each other is actually the existential glue that holds us together as a society. An institution that can carry the value of caring for the whole society can equally carry the value of not caring, if what we do is either not care or even just appear not to care. I think some of the outrage that we are seeing in Canada — and I get lots of calls in my office — is because suddenly people feel that they are not cared for any more or that there is not an appropriate level of that value of caring. Therefore, when we make these decisions, we have to keep those other, metaphysical aims and possible damages in mind.

The other interesting thing about this situation is that every one of us in Canada is in a conflict of interest, and the reason is as follows. As a taxpayer, I do not want to pay more tax; in fact, I would like to put in a strong plea that I might be allowed to pay less at some point. On the other hand, when I am sick and I go to the Royal Victoria Hospital, I do not want someone to tell me they cannot afford to treat me, or that I have to wait six months for something that should be done now, or that I have to be sent to the United States for radiotherapy treatment or whatever it might happen to be. We have this ambivalence inside ourselves: Yes, we want health care to be right, especially when it is for us or those we love; and no, we do not want to pay any more tax.

Another problem is that part of our societal vision of health care has been founded on the myth that we did everything possible, in terms of health care, for everyone who needed it. Our new information age has absolutely shattered that myth. I think that is only going to become more true.

I see the challenge as how to keep those features of the system that we need, not just for practical health care on the ground but as a Canadian society, and at the same time face the reality that we cannot do everything for everyone that would be of benefit for them, in terms of health care.

It is an incredibly difficult challenge to work out how to do that. I think we have been doing it on a piecemeal basis, we have been doing it according to what hits the front pages of the *National Post* or *The Globe and Mail*, and we do not have a coherent approach.

de la société dans son ensemble. En conséquence, quoi que nous fassions, la question n'est pas seulement de savoir si telle ou telle personne ou telle ou telle population aura de meilleurs soins de santé mais plutôt, quand nous prenons ces décisions, que faisons-nous du point de vue des valeurs?

Si la santé est tellement importante, c'est parce que, alors que la plupart de nos collectivités avaient créé autrefois ce qu'on peut appeler leur «paradigme culturel-sociétal», c'est-à-dire au fond simplement un discours commun que nous acceptions tous, essentiellement par le truchement de la religion, dans une société contemporaine nous devons le créer par le truchement d'une institution séculière. Nous le créons généralement par le truchement d'une institution dont l'une des valeurs est de prendre soin d'autrui car prendre soin d'autrui est en fait le ciment existentiel qui nous tient ensemble comme société. Une institution qui a pour valeur de prendre soin de toute la société pourrait aussi bien avoir comme valeur de ne pas prendre soin si nous en arrivions à ne plus nous préoccuper d'autrui ou à simplement en donner l'impression. J'ai le sentiment que les réactions d'outrage que nous voyons aujourd'hui au Canada — et je reçois beaucoup d'appels dans mon bureau — s'expliquent parce que les gens ont soudainement le sentiment qu'on ne prend plus assez soin d'eux ou qu'on n'attache plus autant de prix à la notion d'altruisme. De ce fait, quand nous prenons ces décisions, nous devons tenir compte de ces autres buts métaphysiques et des dommages possibles.

L'autre aspect intéressant de cette situation est que chacun d'entre nous, au Canada, est en conflit d'intérêts, et voici pourquoi. À titre de contribuable, je ne veux pas payer plus d'impôt; en fait, je réclame avec vigueur le droit d'en payer moins. En revanche, si je tombe malade et que je vais à l'Hôpital Royal Victoria, je ne veux pas que l'on vienne me dire qu'on n'a pas les moyens de me soigner, que je devrai attendre six mois pour quelque chose qui devrait être fait tout de suite ou que je devrai aller aux États-Unis pour une radiothérapie ou un traitement quelconque. Il y a donc cette ambivalence dans chacun d'entre nous: nous voulons des soins de qualité, surtout pour nous-mêmes et pour les gens qui nous sont chers, mais nous ne voulons pas payer plus d'impôt.

Un autre problème est que cette vision de la santé dans notre société repose sur le mythe que nous avons toujours fait tout ce qui était possible, du point de vue de la santé, pour tous ceux qui en avaient besoin. L'ère contemporaine de l'information a fait éclater ce mythe et je crois que cette tendance ne peut que continuer.

Le défi est maintenant de conserver les éléments du système dont nous avons besoin, pas seulement pour des questions concrètes de soins mais en tant que société canadienne, tout en confrontant la réalité qui est que nous ne pouvons plus tout faire pour tout le monde.

C'est un défi extrêmement difficile à relever. Nous avons jusqu'à présent tenté de le faire au coup-par-coup, selon ce qui faisait la manchette du *National Post* ou du *Globe and Mail*, mais pas dans une démarche cohérente.

I think there are a multitude of suggestions that we could make, but I can only mention one or two of them. One is that we know that our society is no longer based on what is called "blind trust", which says, "Trust me, because I know what is best for you and will look after you." That is a paternalistic system. We see that very forcefully in the area of medicine in particular. With the requirements of the doctrine of informed consent, which Professor Shanner is going to talk about, we have changed to what is called "earned trust." That says, "Trust me, because I will show that you can trust me, and you only need continue to trust me while I continue to earn your trust." Blind trust, by contrast, is based on power, status, and authority. You will not have trust present if it is based on earned trust and you are not earning it. Again, I think there are problems in the health care system right at the governmental level. I would suggest to you that a lot of Canadians are not sure that their trust is being earned at the level of whether health care will be provided for them and those they love when they need it.

In that respect, I think you need to do some very particular soul-searching as politicians. I think I can call you politicians in the Senate, although in some ways perhaps you are not. One of the most unpopular suggestions I have made to politicians is implicit in the question of whether it would be ethically required of you, as the decision makers about what will constitute our Canadian health care system, to be absolutely subject, as any ordinary citizen would be, to the basic access to that system? In other words, do you, when you are older and influential, politically well connected, socio-economically well-off, get a transplant if someone who is just an ordinary, average Canadian, would not? This is a very difficult question, but I think it has to be faced.

One way to look at health care is to see it as a lifeboat, and realistically, that is what it is. No matter how much we talk about putting money into early childhood care, which I think is ethically required and good, ultimately, we still face maximum health care costs for people when they are older and chronically ill and, later on, dying.

The only difference is that we face them at 80 or 90 years of age instead of at 50 or 60 or 70. We still face them, unless people simply drop dead, which is becoming less likely with our new health care. There is now more that we can do, that we can afford to do, and the real ethical challenge is to work out how we can make those choices without being unethical either in the health care system or in the larger society.

I would also point out that we have grossly underdeveloped organizational or institutional health care ethics at the moment. We have fairly well developed clinical ethics. That is important, because the ethics can differ at the different levels. There are essentially four levels: The micro or individual; the meso or institutional; the macro or societal or governmental; and we have

Je pense qu'on pourrait faire une multitude de suggestions mais je n'en mentionnerai qu'une ou deux. La première est que nous savons que notre société ne repose plus sur ce qu'on appelait la «confiance aveugle», où l'on disait: «Faites-moi confiance car je sais ce qu'il vous faut et je vais m'occuper de vous». C'était là une attitude paternaliste qui était très présente dans le secteur de la médecine en particulier. Avec la doctrine du consentement éclairé, dont Mme Shanner vous parlera, nous sommes passés à un système de «confiance méritée», où l'on dit: «Faites-moi confiance parce que je vais vous montrer que vous le pouvez, et vous ne devrez me faire confiance que tant et aussi longtemps que je mériterai votre confiance». La confiance aveugle, quant à elle, repose sur le pouvoir, le statut et l'autorité. Vous n'aurez donc pas ma confiance si vous ne la méritez pas. Je pense qu'il y a actuellement des problèmes dans le système de santé au niveau gouvernemental. Et j'affirme que beaucoup de Canadiens n'ont pas la conviction que leur confiance est méritée lorsqu'il s'agit de savoir s'ils auront les soins dont ils ont besoin, pour eux et pour ceux qui leur sont chers.

Dans ce contexte, j'estime qu'il vous appartient d'entreprendre une sérieuse réflexion, vous, les politiciens. Je pense pouvoir dire que vous êtes des politiciens, au Sénat, même si vous n'en êtes peut-être pas vraiment. L'une des suggestions qui est le moins bien accueillie quand je m'adresse aux politiciens est implicite dans la question de savoir ce qui serait exigé de vous, sur le plan de l'éthique, en tant que décideurs de notre futur système de santé, si vous étiez tout aussi assujettis que les autres citoyens aux conditions fondamentales d'accès au système. Autrement dit, est-ce que vous, personnes d'âge mûr et influentes, socio-économiquement prospères et ayant des connexions politiques, obtiendriez une greffe d'organe qu'un Canadien moyen ordinaire n'obtiendrait pas? C'est une question très difficile mais je pense qu'il faut y faire face.

Une manière d'envisager le système de santé est de le considérer comme une bouée de secours et, soyons réalistes, c'est ce que c'est. Quoi que l'on puisse dire de l'augmentation des budgets pour la petite enfance, chose que j'estime éthiquement nécessaire et bonne, c'est quand même toujours pour les personnes plus âgées, chroniquement malades et mourantes que nous devons en fin de compte assumer les coûts maximums du point de vue de la santé.

La seule différence est que nous y faisons maintenant face à 80 ans ou 90 ans au lieu de 50, 60 ou 70 ans. Nous sommes obligés d'y faire face, à moins que les gens ne meurent subitement, ce qui est de moins en moins probable avec notre système de santé actuel. On peut aujourd'hui faire plus, parce qu'on en a les moyens, et le vrai problème d'éthique est de faire les choix qui s'imposent sans violer les principes d'éthique, que ce soit dans le système de santé lui-même ou l'ensemble de la société.

J'ajoute aussi que nous avons actuellement, au niveau organisationnel ou institutionnel, une éthique de la santé grossièrement sous-développée, ce qui n'est pas le cas sur le plan clinique. C'est important parce que l'éthique n'est pas nécessairement la même aux différents niveaux. Il y a en fait quatre niveaux: micro ou individuel; méso ou institutionnel;

added to that recently the mega, which is the global level, which can also indeed influence our health care. In fact, one of the things most influencing Canadians' claims for very high-tech, high-level health care currently is they are going on the Internet and seeing what is available, particularly in the United States.

One of my colleagues who is a physician phoned me the other day to say he does not know what to do because he is absolutely beside himself about lack of time. He has people coming into his office who have received a diagnosis, who have gone on the Internet, who have 200 pages of print-out, and they sit down and they say, "Doctor, I would like to start here and discuss this with you." He phoned me to say that he was telling them, "Look, I have 20 minutes to see you. We can do one of two things. We can either talk about what you found on the Internet, or I can examine you and see how well you are doing and prescribe what you need, but I do not have time to do both."

We are fuelling people's claims at the very time that we cannot provide for them. This has been referred to as "the cost of our success." If we had failed, we would not be here today because there would not be anything we would have to worry about being able to pay for or not. It is because our medical research been so incredibly successful, especially in the last 15 years, that we have those dilemmas. They will not go away. They will increase. We need structures within which we can make these decisions.

To conclude, we are in a bind because we have two conflicting aims with medicare. There is the very practical aim of providing health care on the ground at a reasonable level with reasonable access to all Canadians who need it. At the same time, medicare carries a vision of our Canadian society and its values. It must operate on both those levels. What might be reasonable for one of those functions may not be for the other.

After thinking about this and writing it down, I came to the conclusion that if we want it to continue to function as a very important, value-creating mechanism, probably we have to give the most attention to what we need to do in practice in providing health care. No matter what we say, if we do not do that, people will not find the values that they need in our health care system. We should keep in mind it is often said that the ethical tone of a society is best tested by how it treats its weakest, most in need, most vulnerable members. For most of us, the only time we experience that is when we are sick. It is very important then.

The Chairman: Thank you. I will ask Professor Shanner to make her comments.

Ms Laura Shanner, Professor, University of Alberta: Thank you very much for inviting us here today. I will confine myself to some very scattered remarks to which you can refer later. I have previously made available a copy of an extended outline with this set of titles. It cannot possibly be read in 10 minutes, so I will not

macro ou sociétal et gouvernemental; et nous y avons ajouté récemment le niveau méga, qui est le niveau mondial, lequel peut aussi influencer sur notre système. De fait, l'une des choses qui poussent le plus les Canadiens à réclamer des soins de très haut niveau technologique est qu'ils peuvent voir ce qui existe ailleurs, notamment aux États-Unis, grâce à Internet.

Un de mes collègues médecins m'a téléphoné l'autre jour pour me dire qu'il ne sait plus quoi faire parce qu'il est toujours débordé et qu'il manque de temps. Certaines personnes qui arrivent à son cabinet pour un diagnostic lui présentent 200 pages de documents trouvés sur Internet en lui disant: «Docteur, je voudrais commencer par discuter de ceci avec vous». Il m'a me dit qu'il leur répond: «Écoutez, j'ai 20 minutes à vous consacrer. Vous avez donc le choix: ou nous discutons de ce que vous avez trouvé sur Internet, ou je vous examine et je vous prescris des médicaments pour vous guérir, mais je n'ai pas le temps de faire les deux.»

Nous amenons ainsi les gens à demander plus au moment même où nous ne pouvons plus le leur donner. C'est ce qu'on appelle parfois «le prix du succès». Si nous avions échoué, nous ne serions pas ici aujourd'hui parce que nous n'aurions pas à nous demander si nous sommes capables de payer ou non des choses qui n'existeraient pas. C'est parce que notre recherche médicale connaît un succès tellement incroyable, surtout depuis 15 ans, que nous faisons face à ces dilemmes. Ils ne disparaîtront pas. Ils vont se multiplier. Nous avons donc besoin de structures pour prendre ces décisions.

En conclusion, nous sommes dans l'impasse parce que nous visons deux objectifs contradictoires avec l'assurance-santé. Nous avons l'objectif très concret de dispenser des soins de qualité raisonnable, en garantissant un accès raisonnable à tous les Canadiens qui en ont besoin. En même temps, notre système de santé reflète une vision de la société canadienne et de ses valeurs. Il doit donc fonctionner à ces deux niveaux mais ce qui peut être parfaitement raisonnable dans un cas peut fort bien ne pas l'être dans l'autre.

Après avoir préparé mes notes, j'en suis venue à la conclusion que, si nous voulons que le système continue de fonctionner comme mécanisme très important de création de valeurs, nous devons peut-être accorder l'attention maximum à ce qu'il faut faire en pratique pour dispenser les soins. Si nous ne faisons pas cela, les gens ne trouveront pas dans le système de santé les valeurs dont ils ont besoin, quoi que nous puissions leur dire. On dit souvent que la valeur éthique d'une société se juge à la manière dont elle traite les plus faibles de ses membres, ceux qui ont le plus de besoins et qui sont le plus vulnérables. Pour la plupart d'entre nous, le seul moment où nous en faisons l'expérience, c'est quand nous sommes malades. À ce moment-là, c'est très important.

Le président: Merci. Je donne maintenant la parole à Mme Shanner.

Mme Laura Shanner, professeure, Université de l'Alberta: Merci beaucoup de nous avoir invitées aujourd'hui. Je vais me limiter à quelques remarques reliées à mon texte, que vous pourrez lire plus tard. J'avais préparé un document un peu plus étoffé mais il me serait absolument impossible de le lire en

even try, but I will hit some highlights. I have also included a chapter I wrote for a health law practice manual on theoretical approaches to health ethics and its relationship to the law.

To start, we might even define ethics. One key element is that it regards others. Selfishness or self-regard is never considered an ethical principle or framework. There is, of course, reasonable self-interest insofar as we do not need to destroy ourselves in an effort to save others. There is a point at which our interests must be held to be equal with those of others. There may be times when we must accept sacrifices or compromises because the needs of others are more overwhelming.

Universality implies that anything I would expect you to do, I must expect of myself. Professor Somerville mentioned justification. This is not an attempt to find good-sounding, ethical words to justify the decision we were planning to make anyway. It is, instead, a requirement that we go back to the beginning, decide what we are trying to achieve, what issues are at stake for everyone who may be affected by this decision, and then to work through not only the most practical set of outcomes and mechanisms, but also juggle the values and the interests of everyone involved.

Finally, ethics must always concern itself with matters of the most serious importance — of course, our health, our opportunities in life, our degree of suffering, and the fact that most of our health care interventions arise in poignant human moments, like the birth of a child or when we confront our own death or the deaths of loved ones. Health care is inherently infused with ethical concerns simply because of its nature.

I point out that public policy is also infused at all levels with those same sorts of concerns. The justification or the point of a policy body is to coordinate the efforts of all in the community to achieve things that are very important, and that we simply are unable to achieve working alone. Once again, the welfare of the community, our opportunities, our overall health status, our ability to succeed together, are very important to us individually.

Finally, it has been said that you cannot manage what you cannot measure. From an ethical perspective, I would refer to you Howard Brody, who pointed out that sometimes the measurable drives out the important. What is important? There is a very long list of different values that infuse our entire lives, not merely health care or health policy. However, in both health care and health policy, the attention to ethical values must be extraordinary, much higher than is required in our daily lives. I will talk about a few of these in greater detail.

The core of health policy tends to focus on the balancing of individual and common interests. One way of understanding this is that the protection of those who are most vulnerable, and respect for persons or individual autonomy, may very often be in

10 minutes. Je ne vais donc même pas essayer. J'ai aussi inclus dans ma documentation un chapitre que j'ai préparé pour un manuel consacré au droit de la santé. Ce chapitre porte sur les approches théoriques de l'éthique de la santé et de sa relation avec le droit.

Pour commencer, nous pourrions peut-être définir l'éthique. L'une de ses caractéristiques principales est qu'elle concerne autrui. L'égoïsme n'a jamais été considéré comme un principe d'éthique. Certes, nous avons un intérêt égoïste raisonnable à ne pas nous détruire en tentant de sauver les autres. Il arrive un moment où nos intérêts doivent être considérés comme égaux à ceux des autres. Dans certains cas, nous pouvons être obligés d'accepter des sacrifices ou des compromis parce que les besoins des autres sont plus écrasants.

L'universalité suppose que j'attende de moi-même tout ce que j'attends de vous. Mme Somerville a parlé de la justification. Il ne s'agit pas d'essayer de trouver de bons termes d'éthique pour justifier une décision que nous avons de toute façon l'intention de prendre. Il s'agit plutôt de l'obligation de retourner au point de départ pour décider ce que nous essayons d'accomplir, examiner les enjeux de toutes les parties susceptibles d'être touchées et ensuite seulement de démêler non seulement l'ensemble le plus pratique de résultats et de mécanismes mais aussi les valeurs et les intérêts de chacun.

Finalement, l'éthique doit toujours porter sur des questions de la plus grande importance — notre santé, bien sûr, mais aussi le cours de notre vie, notre niveau de souffrance et le fait que la plupart des interventions de santé interviennent aux moments humains les plus poignants, comme la naissance d'un enfant, notre propre mort ou la mort d'êtres qui nous sont chers. Le système de santé est donc foncièrement truffé de questions d'ordre éthique, tout simplement parce que c'est sa nature intrinsèque.

J'ajoute que les politiques publiques sont aussi truffées du même type de préoccupations, à tous les niveaux. La justification ou le rôle d'un organisme public est de coordonner les efforts de tous les membres de la communauté pour atteindre les choses qui nous sont très importantes ou que nous ne pourrions tout simplement pas réaliser seuls. Ici encore, le bien-être de la communauté, nos opportunités, notre bilan de santé, notre aptitude à réussir ensemble sont extrêmement importants pour chacun d'entre nous.

Finalement, on a dit qu'on ne peut pas gérer ce qu'on ne peut pas mesurer. Du point de vue de l'éthique, j'attire votre attention sur Howard Brody qui a souligné que ce qui est mesurable chasse parfois ce qui est important. Qu'est-ce qui est important? Nous avons une très longue liste de valeurs différentes qui fondent notre vie, pas seulement le système ou les politiques de santé. Toutefois, dans le système et les politiques de santé, il convient d'accorder une attention extraordinaire aux valeurs éthiques, une attention beaucoup plus élevée que ce qui est nécessaire dans notre vie quotidienne. Je vais examiner quelques-uns de ces éléments de manière plus détaillée.

Le cœur de notre politique de santé a tendance à être axé sur la recherche d'un équilibre entre le bien particulier et le bien commun. On peut présenter cela en disant que la protection des plus vulnérables, le respect de l'individu et l'autonomie

conflict with what is just or fair, or with what is good in terms of the best outcomes.

I suggest that, as we try to balance these individual and common goods, you imagine that you are wearing bifocal glasses, of which one lens lets you see up close. In health care, it would be the patient and the patient's family and loved ones for whom nothing is more important than relieving the pain, delaying the death, achieving a healthy birth, and related concerns. At the individual level, ethics of beneficence and respect for those individuals indicate that we need to do everything humanly possible that may be helpful.

At the same time, we need to use the other lens, the distance lens, which allows us to see the entire community. This is where the justice questions, the allocation and shepherding of resources, and the overall good that we seek to achieve together must be considered. While individuals must never be subsumed or "chewed up" in the attempt to promote public or common goods, we do have to consider that what is best for individuals may not be best, and may even be harmful, for the collective. We need to somehow look out of both lenses at the same time without getting dizzy. This is quite a challenge.

As you can see, with multiple values, it will be very difficult to find a single right answer that achieves everything that needs to be covered. Indeed, this is not a complete list of relevant ethical values.

We might, therefore, focus on ethics not so much as the outcome of the specific yes or no answer, but as a matter of process — how we engage in our reasoning, what we take into account, whether we are acting in an accountable and virtuous way. Whether we do in fact care about the results or that our deliberations occur from a position of genuine compassion for our fellow human beings, recognizing that every choice will leave something undone. Some of these may not be as well protected as we need them to be and that may leave what is called "a moral residue."

Let me discuss a core principle, non-maleficence, which simply means, do not hurt people. This is the most binding, most minimal limit of ethical behaviour: Above all else, no matter what else you do, even if you do not actively try to help someone, for heaven's sake do not leave people less well-off than they were before. In a clinical context, this would refer to the physical safety of patients and their medical outcomes, their emotional well-being, and of those who are related to or care about them, and respect for their personal values and life situations. There may be things that individuals cannot or will not sacrifice for other goods. Those values may not be consistent among members of the health care team and the patients or families, or the policy bodies and the larger social orientation.

individuelle peuvent très souvent entrer en conflit avec ce qui est juste ou équitable, ou avec ce qui est bon du point de vue des résultats.

Pour montrer comment nous essayons d'équilibrer le bien particulier et le bien commun, imaginez que vous portez des lunettes à double foyer dont une lentille vous permet de voir de très près. Dans le secteur de la santé, il s'agirait du patient, de sa famille et de ses proches, pour qui rien n'a plus d'importance qu'éliminer la douleur, retarder la mort, accoucher d'un bébé en santé, et cetera. Au niveau particulier, l'éthique de la bienfaisance et du respect des personnes dicte que nous fassions tout ce qui est humainement possible pour être utiles.

Il faut cependant utiliser en même temps l'autre lentille, celle qui permet de voir de loin, pour tenir compte de toute la collectivité, et c'est ici qu'apparaissent alors des questions de justice et de répartition et de protection des ressources, et c'est ici que l'on doit tenir compte du bien commun que l'on essaie d'atteindre. Certes, l'individu ne doit jamais être pris pour acquis ou être «dévoreré» par l'effort de promotion du bien public ou commun, mais il ne faut pas oublier que ce qui est préférable pour l'individu ne l'est pas nécessairement pour la collectivité et risque même d'être nuisible. Nous sommes donc obligés de regarder à travers les deux lentilles en même temps sans perdre la tête, ce qui est tout un défi.

Comme vous pouvez le constater, il sera très difficile, avec des valeurs multiples, de trouver une seule bonne réponse à toutes les questions qui se posent, sans compter que ceci n'est même pas une liste complète des valeurs éthiques pertinentes.

Nous pourrions donc envisager l'éthique non pas tant comme le résultat d'une réponse précise par oui ou par non mais comme une question de processus — comment nous entreprenons notre réflexion, qu'est-ce que nous prenons en considération, et est-ce que nous agissons de manière responsable et vertueuse. Autrement dit, est-ce que les résultats comptent vraiment pour nous et est-ce que nous entreprenons notre réflexion en faisant sincèrement preuve de compassion envers autrui, étant bien entendu que chaque décision nous oblige à renoncer à quelque chose. Certaines personnes risquent de ne pas être aussi bien protégées que nous le voudrions, ce qui risque de laisser ce que j'appellerais un «résidu moral».

Voyons par exemple un principe fondamental, la non-malfaisance, qui veut simplement dire ne pas causer de tort à autrui. C'est la limite la plus élémentaire et la plus exigeante de tout comportement éthique. Quoi que l'on fasse, même si l'on n'essaie pas activement d'aider quelqu'un, le minimum est de faire en sorte que l'autre ne se retrouve pas dans une situation pire qu'avant. Dans un contexte clinique, cela veut dire qu'il faut assurer la sécurité physique des patients et des résultats médicaux, assurer le bien-être émotionnel des patients, de leurs proches et des personnes qui s'en occupent, et respecter leurs valeurs personnelles et leur situation de vie. Il peut fort bien y avoir des choses que certaines personnes ne pourront ou ne voudront pas sacrifier pour d'autres biens. Ces valeurs ne sont pas nécessairement les mêmes pour tous les membres de l'équipe de soins, pour tous les patients ou pour toutes les familles, ni même

One of the most important problems that we see with Alberta's Bill 11 fits in here, under clinical best interests. By setting up what has been referred to as a "non-hospital hospital," the non-hospital, long-stay surgical centre, we create a real concern for the welfare of patients following surgery. Why would you need to stay overnight after surgery? It is not so that nurses can notice if you happen to go into crisis. It is so that someone who is prepared to help you with whatever sort of post-surgical complication might arise is there to do so. These non-hospital surgical centres would not have a full staff of clinical specialists in cardiovascular disease or neurological complications, or complications with respect to any other body part that might be injured. They would not be training medical residents. Who exactly is going to be on call at three o'clock in the morning when the highest-ranking surgeons in an area have gone home for the day? There are very serious concerns there.

Let me deal with the policy effort to protect and strengthen public goods rather than undermine them. If we talk about an approach dealing with the whole health system rather than a piecemeal one, again Bill 11 fails. What good is there in providing for surgery when the real crunch in the health care system involves recovery beds, not surgical centres? Again, we have to look at health promotion and protection, the areas of poverty relief, education, environment, all of those important things.

My next topic is justice, the fairness of allocation. There are several different forms of justice. The most important one for health care is social justice: relative poverty or wealth, access to opportunities, access to health care. Certainly, it is very clear that those of us who work in allied health professions know the right people. I can easily get in to see a specialist. I know the language, I can do the research, and I have connections I can call. Other people are not as lucky. That disparity in availability of access is a significant moral issue.

I would also call attention to what have been called the "natural lottery" and "social lottery." Whatever we may have worked hard in our lives to earn, we did not earn our parents or our genetic endowment. We did not earn the society in which we live, whether it is racist and discriminatory, or one that truly values equal access, equal justice, and non-discrimination. The fact is that, wherever we start from, which is utterly beyond our control, may greatly affect our health status and need for health care and may also set the ground for our ability to acquire resources to access that care later. That needs to be taken into account when primary goods are at stake, such as the ability to feel relief from suffering, to engage in education or employment, to take care of family members. It is not fair to limit access to health care based upon initial conditions that could not be controlled.

pour tous les organismes d'élaboration des politiques et pour la société dans son ensemble.

À nos yeux, l'un des problèmes les plus importants que pose le projet de loi 11 de l'Alberta tombe précisément dans cette catégorie, c'est-à-dire le meilleur intérêt clinique. En établissant ce que l'on a appelé un «hôpital qui n'en est pas un», c'est-à-dire un centre de chirurgie de long séjour, on suscite des inquiétudes réelles pour le bien-être des patients après la chirurgie. Pourquoi doit-on rester à l'hôpital après une chirurgie sinon pour que les infirmières puissent intervenir en cas de crise? Sinon pour que quelqu'un soit prêt à agir en cas de complications quelconques après l'opération? Or, ces centres de chirurgie qui ne sont pas des hôpitaux n'auront pas un effectif complet de spécialistes cliniques en maladies cardiovasculaires ou en complications neurologiques ou en complications post-opératoires quelconques. Ces hôpitaux qui n'en sont pas ne formeront pas de médecins en résidence. Qui sera donc sur place à 3 heures du matin quand les chirurgiens de la région seront tous rentrés dormir? Ces questions sont loin d'être sans importance.

Parlons maintenant du souci des pouvoirs publics de protéger et de renforcer les biens publics plutôt que de les miner. Si la politique consiste à régir tout le système de santé de manière globale plutôt qu'au coup-par-coup, le projet de loi 11 s'avère à nouveau déficient. Quel intérêt y a-t-il à créer un centre de chirurgie quand le vrai problème concerne le manque de lits de récupération, pas le manque de salles opératoires? Encore une fois, on devrait tenir compte de la promotion et de la protection de la santé, de la lutte contre la pauvreté, de l'éducation et de l'environnement, toutes choses qui sont importantes.

Qu'en est-il de la justice, c'est-à-dire de l'équité dans la répartition des ressources? Il y a plusieurs formes différentes de justice. La plus importante, sur le plan de la santé, est la justice sociale: pauvreté ou richesse relative, accès aux opportunités, accès aux soins. À l'évidence, ceux d'entre nous qui travaillons dans des professions reliées à la santé connaissons les bonnes personnes. Je n'aurais aucun mal à voir un spécialiste. Je sais ce qu'il faut dire, je peux faire les recherches et j'ai des contacts. Les autres n'ont sans doute pas autant de chance. Cette disparité dans l'accessibilité des soins est une question importante d'ordre moral.

J'attire aussi votre attention sur ce que d'aucuns appellent la «loterie naturelle» et la «loterie sociale». Chacun d'entre nous peut fort bien travailler dur dans sa vie pour faire des choix, mais personne ne choisit ses parents ni son patrimoine génétique. Personne ne choisit la société dans laquelle il vit, qu'elle soit raciste et discriminatoire ou sincèrement fondée sur l'égalité d'accès, l'égalité de justice et l'absence de discrimination. Le fait est que, quel que soit notre point de départ, lequel ne relève absolument pas de notre contrôle, il risque d'influer considérablement sur notre état de santé et sur notre besoin éventuel de soins, et il risque aussi de déterminer notre aptitude à acquérir les ressources nécessaires pour avoir accès aux soins plus tard. On se doit de tenir compte de ce facteur lorsqu'on parle de biens primaires comme la possibilité d'éliminer la souffrance, de faire des études, d'obtenir un emploi ou de prendre soin de sa famille. Il n'est pas juste de limiter l'accès à la santé en fonction de circonstances initiales absolument hors de notre contrôle.

There are several different criteria of distribution. Need, equal access, and, to some extent, first-come-first-served, are crucial to health care systems. These other options of merit, equal shares, or by lottery or random chance, may be helpful in other domains, but not in health care.

It has been observed that the need for health care is literally infinite. We are mortal creatures, and every time our lives are saved, the one guarantee is that we will return with another life-threatening complication. Further, as we take care of the big issues — my life is not currently threatened — we become aware of less compelling ones and seek treatment for them, too. This extends to medical cures for baldness or toenail fungus, among other things, while other, more serious health care needs may go unmet.

Informed consent is a foundation of health care, insofar as treatment administered to a patient without free, voluntary, informed consent is a form of assault. It is also foundational in health policy. If a team is elected without the informed population, then people do not know what they have agreed to. If a decision is made that is not part of the elected mandate, then again there has been no information and little or no opportunity for consent. This would be an important concern, in my view, about the process surrounding Bill 11 in Alberta, since three times now the public has said they do not wish increased privatization. Nevertheless, as of last night, the government has passed Bill 11, with closure actually used at all three levels — at first, second and third reading — to end debate prematurely.

Disclosure requires the utmost in honesty, first, in providing available information and admitting what we do not know. Special attention must be paid to risks. Again, in the Bill 11 context, the risks concerning NAFTA implications of increasing privatization and overnight stays in for-profit facilities are real.

We need to promote understanding through a genuine dialogue, giving equal consideration to all available evidence, rather than directing it in a certain way.

Next is voluntariness. Again, there are concerns with the process in Bill 11. The manipulation of wording leading us to the non-hospital hospital is an excellent example. The definitions are placed at the end of the bill rather than up front, as is typical, so that the actual definition of a private hospital escapes most people's attention unless they know already what they are looking for.

Let me talk about external coercion factors. Holding the Tory Party caucus to a party vote rather than a vote of conscience, or according to constituents' wishes, is in fact a form of coercion. Again, the rush to push the bill through despite protests seems to be a coercive factor as well.

Il y a plusieurs critères différents de distribution. Le besoin, l'égalité d'accès et, dans une certaine mesure, le principe du premier arrivé, premier servi, sont cruciaux pour les systèmes de santé. Les autres facteurs de mérite, de parts égales ou de répartition aléatoire ou par loterie peuvent être utiles dans d'autres domaines mais pas dans le secteur de la santé.

On dit parfois que le besoin de santé est littéralement infini. Nous sommes mortels et, chaque fois qu'on nous sauve la vie, la seule garantie que nous ayons, c'est que nous serons à nouveau confrontés à la mort. En outre, à mesure que nous réglons les gros problèmes — ma vie n'est pas menacée en ce moment — nous prenons conscience de problèmes moins urgents et nous essayons également de les faire traiter, ce qui peut aller jusqu'au traitement médical de la calvitie ou d'une mycose, par exemple, alors que d'autres problèmes de santé plus sérieux restent sans traitement.

Le consentement éclairé est l'un des fondements du système de santé dans la mesure où tout traitement administré à un patient sans son consentement éclairé, libre et volontaire est une forme d'agression. C'est aussi un principe fondamental des politiques publiques reliées à la santé. Si une équipe est élue par une population non éclairée, celle-ci ne sait pas à quoi elle consent. Si une décision est prise en dehors du mandat consenti par l'électorat, celui-ci, encore une fois, ne possède pas les informations nécessaires et ne peut donner son consentement. Ce facteur me paraît important dans le cadre du processus ayant entouré le projet de loi 11 en Alberta étant donné que le public a dit à trois reprises qu'il s'opposait à une privatisation accrue des services. Pourtant, le gouvernement a fait adopter le projet de loi 11 hier soir, en ayant imposé la clôture des débats aux trois étapes — en première, deuxième et troisième lectures — pour mettre fin au débat de manière prématurée.

La divulgation exige l'honnêteté maximum, c'est-à-dire la garantie absolue qu'on donne toutes les informations disponibles et qu'on admet en toute franchise celles qu'on ne possède pas. Il importe de prêter une attention spéciale aux risques. Toujours dans le contexte du projet de loi 11, la privatisation croissante des services et l'acceptation de séjours d'hospitalisation dans des établissements à but lucratif posent des risques réels dans le cadre de l'ALENA.

Il nous appartient de favoriser une meilleure compréhension par un dialogue ouvert, en accordant la même attention à toutes les informations disponibles plutôt qu'en essayant d'orienter le débat.

Parlons maintenant du volontariat, pour lequel le projet de loi 11 pose aussi des problèmes. La manipulation de la terminologie amenant à parler d'hôpitaux qui n'en sont pas en est un excellent exemple. Contrairement à l'habitude, les définitions se trouvent à la fin du projet de loi plutôt qu'au début, ce qui veut dire que la définition réelle d'un hôpital privé échappe à la plupart des lecteurs, sauf s'ils savent déjà ce qu'ils cherchent.

Parlons aussi des facteurs externes de coercition. Imposer un vote de parti au caucus conservateur plutôt qu'un vote de conscience ou un vote fondé sur les désirs de l'électorat est en fait une forme de coercition. La précipitation démontrée pour faire adopter le projet de loi malgré les protestations publiques semble aussi être un facteur de coercition.

Next is the coercive factors of a situation. In health care, we need to realize that the patient may be vulnerable, frightened, in pain, compromised by the illness. In politics, we need to understand the limitations of the communication between the public and the policy makers. Attention has not been paid to this except to use those constricting factors to the benefit of the policy agenda.

Since there is need for informed consent, and given the difficulties inherent in truly informed and free consent, we must have a trust relationship of the highest order in both the health care and policy relationships. This is due to the disparity in knowledge or power. There is a duty for the more powerful to not merely avoid trampling on the less powerful, but also to come to their aid, to protect the most vulnerable. We need to understand our motives and choices when we are in positions of power, and we must, therefore, avoid even the appearance of a conflict of interest, let alone an actual one. Violations of this trust will threaten not only the individuals who might be affected, but will also threaten to undermine the entire institution of either health care or the democratic political process.

I have for you a document taken from the New Democratic Party of Alberta Web site, and the address is on the copy. This outlines the shareholders of the Health Resources Group, which is now based at the old Grace Hospital in Calgary.

Jim Saunders is the former chief operating officer of the Calgary Regional Health Authority. The RHAs are supposed to be at arm's-length from the government in power. However, other Calgary Health Authority members include Jack Davis, a former secretary to the provincial cabinet, and Jim Dinning, the former treasurer. There are several members who are involved in a variety of health care investment firms that have all paid into supporting the Health Resources Group. This is clearly the motivation for Bill 11.

The initial representation was that Bill 11 would reduce the waiting list for hip replacements. On the grounds of danger to patients, the college of physicians and surgeons said that would not be acceptable.

A second attempt was made to justify overnight-stay surgery with appendectomies, which are not elective but emergency procedures. You would need a full emergency room and staff for non-appendicitis cases of abdominal pain.

Now they have hit upon hernias, as is done at the Shouldice Hospital in Ontario. Again, HRG is an orthopedic centre. It looks as if this is a bill looking for a procedure to justify it rather than a clear response to the needs of the health care system.

I will stop there. There is much more to be said, both about ethics in policy and in health care provision, and about Bill 11, but I am open to questions.

Viennent après cela les facteurs de coercition de la situation. Dans le secteur de la santé, il est essentiel de comprendre que le patient peut être vulnérable, peut avoir peur, peut souffrir et peut être affaibli par la maladie. En politique, il faut comprendre les limites de la communication entre le public et les décideurs. On n'a prêté aucune attention à cela sauf pour exploiter ces facteurs limitatifs afin de faire adopter le projet de loi.

Considérant l'obligation du consentement éclairé et les difficultés inhérentes à obtenir un consentement vraiment éclairé et libre, il est essentiel d'établir une relation de confiance de la plus haute qualité possible entre la population et les décideurs publics du domaine de la santé. Cela s'explique par la disparité du savoir et du pouvoir. Les puissants ont le devoir non seulement de ne pas écraser les moins puissants mais aussi de leur venir en aide, de protéger les plus vulnérables. Il nous appartient de comprendre nos motifs et nos choix quand nous occupons un poste de pouvoir, et nous devons donc éviter de donner ne serait-ce que l'apparence d'un conflit d'intérêts. Violer cette relation de confiance menace non seulement les personnes qui risquent d'être touchées mais aussi l'institution dans son ensemble, qu'il s'agisse du système de santé ou du système politique démocratique lui-même.

Je vous ai apporté un document provenant du site Web du Parti néo-démocrate de l'Alberta. L'adresse y figure. Il s'agit d'une liste des actionnaires du Health Resources Group, qui est maintenant basé à l'ancien Hôpital Grace de Calgary.

Jim Saunders est l'ancien chef de la direction de l'Autorité régionale de la santé de Calgary. Les ARS sont censées être totalement indépendantes du gouvernement mais on constate que celle de Calgary comprend parmi ses membres Jack Davis, ex-secrétaire du Cabinet provincial, et Jim Dinning, ex-trésorier. On y trouve aussi plusieurs membres reliés à diverses firmes d'investissement dans le secteur de la santé qui ont toutes contribué financièrement à appuyer le Health Resources Group. Voilà la motivation évidente du projet de loi 11.

À l'origine, on justifiait le projet de loi 11 en disant qu'il réduirait les listes d'attente pour les remplacements d'articulations de hanche. Pour des raisons de danger pour les patients, le Collège des médecins et chirurgiens a déclaré que ce ne serait pas acceptable.

On a donc fait une deuxième tentative de justification de la chirurgie de long séjour en parlant des appendectomies, qui ne sont pas des procédures facultatives mais d'urgence. On aurait besoin d'une salle d'urgence et d'un personnel complet pour les cas de douleur abdominale non causée par l'appendicite.

Maintenant, on parle de hernies, comme en fait l'Hôpital Shouldice en Ontario. Je répète, HRG est un centre d'orthopédie. Il semble que l'on ait en fait un projet de loi cherchant sa justification plutôt qu'un texte constituant une réponse claire aux besoins réels du système de santé.

Je vais en rester là. J'en aurais encore beaucoup à dire, tant au sujet de l'éthique dans l'élaboration des politiques publiques et dans la prestation des soins de santé qu'au sujet du projet de loi 11, mais je vais me mettre à votre disposition pour répondre à vos questions.

The Chairman: Before turning to Senator Keon, I would like to make several observations, initially to Professor Shanner, about her comments on Bill 11. I do not want to be taken as a supporter of Bill 11, but I have great difficulty with some of your conclusions.

You seem to feel that it is unethical for governments to proceed with legislation to which the public is very opposed.

On that basis, this country would never have abolished capital punishment in 1975. I regard that legislation as one of the more positive things that I have been involved in in my life. Every poll repeatedly showed that 80 per cent of the public was adamantly in favour of capital punishment. In fact, I have difficulty with the premise that it is an ethical issue — because it clearly is not — for governments to do things to which there is massive public opposition.

It seems to me the point of government is to lead. It is very clear that you do not like the way it is leading, but that is a value judgment that is difficult to elevate to the level of ethics.

Dr. Shanner: May I respond?

The Chairman: Certainly.

Dr. Shanner: I certainly would not agree with the blanket statement that governments should never act in ways that are contrary to public opinion. The way governments should and must act, however, is first with careful collection and evaluation of all available evidence — for example, as this committee is undertaking.

In the case of Bill 11, there is very great evidence from New Zealand, Australia, and Great Britain about the effects of increased privatization in an otherwise public system. Further, there is evidence about Alberta's own practice of mixing public and private care regarding ocular surgery for cataract replacements.

When this information was raised in debate, it was summarily dismissed. Indeed, most of the researchers who have presented such information have actually been called such unsavoury names as “whiners, complainers, and left-wing nuts.”

The Chairman: That is minor compared to what members of this committee have been called. It is hard for us to be sympathetic.

Dr. Shanner: There is always going to be disagreement about values. There will always be disagreement over how to set the priorities. There will always be times in which all of us will tend to act out of what we are used to and comfortable with, rather than going back to the beginning and thinking it all the way through.

In the example of capital punishment, for instance, the moral argument supporting the death penalty is really rather dodgy. Does the death penalty deter crime? The answer, through evidence, is clearly no. Is the death penalty cheaper than incarceration? The evidence indicates no, it is not. Is there any good reason to

Le président: Avant de donner la parole au sénateur Keon, j'aimerais faire plusieurs remarques, d'abord à la professeure Shanner au sujet de ce qu'elle a dit sur le projet de loi 11. Sans vouloir donner l'impression que j'appuie le projet de loi 11, je dois dire que j'ai de sérieuses réserves sur certaines de vos conclusions.

Vous semblez penser qu'il n'est pas éthique pour un gouvernement d'adopter un projet de loi auquel le public est très opposé.

Si tel était le cas, nous n'aurions jamais aboli la peine capitale en 1975. Or, je considère que cette décision est l'une des plus positives auxquelles j'ai participé dans toute ma vie. À l'époque, tous les sondages montraient que 80 p. 100 de la population appuyait vigoureusement la peine capitale. En fait, j'ai du mal à accepter votre prémisse qu'il y a un problème d'éthique — parce que ce n'est manifestement pas le cas — lorsque le gouvernement fait quelque chose qui suscite une opposition massive de la population.

Il me semble que la fonction d'un gouvernement est de gouverner. Il est clair que vous n'aimez pas la manière dont ce gouvernement gouverne mais c'est là un jugement personnel qu'il est difficile d'assimiler à une question d'éthique.

Mme Shanner: Puis-je répondre?

Le président: Certainement.

Mme Shanner: Je n'approuverais certainement pas l'affirmation à l'emporte-pièce qu'un gouvernement ne doit jamais agir contre l'opinion publique. Par contre, la manière dont un gouvernement doit et devrait agir est d'abord de recueillir et d'évaluer attentivement toutes les données disponibles — comme le fait votre comité, par exemple.

Dans le cas du projet de loi 11, il existe de très nombreuses données de Nouvelle-Zélande, d'Australie et de Grande-Bretagne sur les effets d'une privatisation accrue dans un système public. En outre, des données existent au sujet de l'existence en Alberta même d'un panaché de services publics et privés, c'est-à-dire les cliniques de chirurgie oculaire pour la cataracte.

Quand ces informations ont été incluses dans le débat, on les a balayées d'un revers de main. De fait, la plupart des chercheurs qui ont présenté ces informations ont été qualifiés d'adjectifs aussi peu glorieux que «chialeux, pleurnichards et doux dingues de gauche».

Le président: Ce qui n'est rien par rapport à ce qu'ont déjà entendu certains membres de notre comité. Ce n'est pas ça qui va nous émouvoir.

Mme Shanner: Il y aura toujours des désaccords sur les valeurs. Il y aura toujours des désaccords sur les priorités. Il y aura toujours des moments où nous aurons tous tendance à agir en fonction de nos habitudes et de ce avec quoi nous sommes à l'aise plutôt qu'en repensant le problème depuis le début.

Dans le cas de la peine capitale, par exemple, l'argument moral en faveur de cette sanction est vraiment douteux. Est-ce que la peine capitale dissuade les criminels? Toutes les preuves disponibles démontrent que non. Coûte-t-elle moins cher que l'incarcération? Encore une fois, les preuves montrent que non.

commit capital punishment, short of seeking vengeance out of the anger of those in the community who have been hurt? Since that is the only reason to go forward, and the reasons against continuing the death penalty are significant, the best answer is to end the death penalty and lead the public into revising its opinion based on a better discussion of what is known.

The problem with Bill 11 is that there is quite a lot of information. It is being discussed by a large percentage of the population, but not effectively at the policy-making level.

Further, what is the justification for Bill 11? There does not seem to be much. The main benefit will be to regulate contracts with private facilities. This speaks only to surgeries. It does not speak to private diagnostic facilities, private clinical facilities, physiotherapy centres. There are all kinds of private facilities. This bill does nothing to address that very legitimate concern. In fact, what it does primarily is open up overnight stays at for-profit private centres, which the government's own blue-ribbon panel last year identified as "hospitals." A non-hospital hospital remains a hospital.

Third is the concern about the use of coercive forces and manipulative language. If this is worth doing, let's talk about why. Simply to use slogans or name calling or to refuse to discuss the other side of the question is simply not an appropriate approach.

Those are my concerns.

The Chairman: On that basis, you would disagree with the vast majority of major legislative approaches by governments of all parties, federally and provincially, if you think that the use of slogans, party whips, and a variety of other things are not appropriate mechanisms for changing public policy. I am not even sure I disagree with you on that. I merely observe that much of what you have said would apply to a whole variety of things done by all parties across the country.

Let me make one other, general comment. I would like to move away from Bill 11 for a minute.

There is an implicit position, and perhaps in the case of Professor Somerville it was explicit, that in many of these questions there is a "right" answer.

Dr. Somerville: No.

Dr. Shanner: There are better answers and there are some that are clearly inappropriate.

The Chairman: "Better" is a value judgment. If I give you five answers, you can tell me that one is better than the other. In many of these issues, there is a judgment at the end and it is difficult to classify it as better or worse, since better, inevitably, has to be based on the decision-maker's personal values. I do not know how you avoid that problem.

Y a-t-il une seule bonne raison pour commettre la peine capitale, si ce n'est pour permettre aux membres de la société qui ont souffert du crime d'obtenir vengeance? Comme c'est la seule raison pouvant justifier la peine capitale, et comme toutes les raisons contre sont importantes, la meilleure solution est d'y mettre fin et d'amener le public à revoir son avis à partir d'un meilleur débat fondé sur les faits.

Le problème du projet de loi 11 est qu'il y a beaucoup d'informations. Il fait l'objet d'un débat dans une grande partie de la population, mais pas efficacement au niveau de l'élaboration des politiques.

En outre, qu'est-ce qui justifie le projet de loi 11? Apparemment, peu de choses. Son principal avantage sera de réglementer des contrats avec des établissements privés et seulement en ce qui concerne des opérations chirurgicales. Il ne porte pas du tout sur les établissements de diagnostic, les cliniques privées, les centres de physiothérapie. Or, il existe toutes sortes d'établissements privés. Ce projet de loi ne porte absolument pas sur cette préoccupation très légitime. De fait, sa conséquence essentielle sera de permettre des séjours d'hospitalisation dans des centres privés à but lucratif que le propre comité des sages du gouvernement a qualifiés l'an dernier d'hôpitaux. Un hôpital qui n'en est pas un reste un hôpital.

Troisièmement, il convient de s'inquiéter de l'utilisation de la coercition et d'un langage manipulateur. Si ce projet de loi vaut la peine d'être adopté, parlons-en. Se contenter de slogans et d'insultes, ou refuser de discuter avec les opposants, n'est tout simplement pas une approche adéquate.

Voilà mes réserves.

Le président: Dans ce cas, vous devriez vous opposer à la grande majorité des mesures législatives importantes adoptées par les gouvernements, quel que soit leur parti, au palier fédéral ou provincial, si vous pensez que l'utilisation de slogans, de la discipline de parti et de beaucoup d'autres choses ne constitue pas une méthode adéquate pour changer les politiques publiques. Je ne suis d'ailleurs pas sûr d'être en désaccord avec vous là-dessus. Je constate simplement qu'une bonne partie de vos remarques pourrait sans doute s'appliquer à toutes sortes de choses que font les partis politiques d'un bout à l'autre du pays.

Je voudrais faire une autre remarque, d'ordre général. J'aimerais laisser de côté le projet de loi 11 pour un instant.

Il semble y avoir dans vos affirmations la position implicite, mais probablement assez explicite dans le cas de la professeure Somerville, qu'il existe une «bonne» réponse à beaucoup de ces questions.

Mme Somerville: Non.

Mme Shanner: Il existe de meilleures réponses et il en existe qui sont manifestement insatisfaisantes.

Le président: «Meilleures», c'est une question de jugement. Si je vous donne cinq réponses, vous pouvez me dire que l'une est meilleure que les autres mais, dans beaucoup de ces domaines, tout se résume en dernière analyse à un jugement personnel et il est difficile de dire que telle ou telle solution est meilleure ou pire étant donné qu'une solution meilleure dépendra inévitablement

Dr. Somerville: I would like to comment on the previous issue that you raised. It is true that you cannot establish ethics by consensus. If you could, the Nazis would be ethical. That is an easy example.

It is also true, and something that we have realized very much more of late, that it makes a vast difference whether we start our analysis of an issue with the law and then consider ethics, as we usually do today, as compared with starting from ethics and then considering law.

The Chairman: I will agree with that.

Dr. Somerville: If I may say so, one of the differences between your position and Professor Shanner's is that she is starting with ethics and then saying, "Having established the ethics, what law should we implement?" She finds Bill 11 unsatisfactory because of her ethical reservations. You say, "Let's use the legal process and see what happens."

Another point I meant to raise in my presentation is that we are very concerned about the ethics of interfering with medicare. I think that is the right approach. On the other hand, we have to be equally concerned about the ethics of denying access to private health care. That does not mean we should make a decision to do that. What it means, and this relates to your question, is that in doing that, we cannot just ethically say that is what we choose, and like it or not, we are going to have it. We have to be able to ethically justify that inhibition/prohibition on private health care. I am not sure that we will be able to do that in the future.

It will be a very complex debate, particularly since the governing ethics will be different at different levels.

To respond to your question about whether ethics is just what I prefer. No, the whole point about ethics is that it is not just what I prefer. It is a structured, analytical approach to a conflict. There are different values and different positions. You may well come out with totally different answers to the same question, depending on the ethical structure that you use for your analysis. However, you must be able to justify your choice. It is the justification of that choice that makes up the ethics.

Almost all of these questions are value judgments, which is why we have a conflict. If we all come to the same answer, we get what we call the "white light of ethical insight," but that does not happen.

Senator Keon: You began to answer the question I was going to raise. Moving again to Bill 11, the big issue facing us all right now is the ethics of holding a population hostage to a single-tier system.

des valeurs personnelles de chacun. Je ne vois pas comment vous évitez ce problème.

Mme Somerville: Je voudrais revenir sur la remarque précédente que vous avez faite. Il est vrai qu'on ne peut pas déterminer l'éthique par consensus. Sinon, les nazis auraient agi de manière éthique. C'était un exemple facile.

Il est vrai aussi, et c'est quelque chose dont on prend de plus en plus conscience ces derniers temps, qu'il y a une très grande différence entre commencer l'analyse d'un problème à partir du droit pour passer ensuite à l'éthique, comme on le fait généralement aujourd'hui, et commencer par l'éthique pour passer ensuite au droit.

Le président: Je suis d'accord avec vous.

Mme Somerville: Je me permets de dire que l'une des différences entre votre position et celle de la professeure Shanner est qu'elle entreprend son analyse à partir de l'éthique, pour dire ensuite: «Les principes d'éthique étant maintenant établis, quelle loi devrions-nous adopter?» Elle estime que le projet de loi 11 est insatisfaisant à cause de ses réserves du point de vue éthique. De votre côté, vous dites: «Adoptons une loi et voyons ce qui se passe.»

Une autre remarque que je voulais faire dans mon exposé est que nous sommes très préoccupées par l'éthique de l'ingérence dans le secteur de la santé. Je pense que c'est la bonne approche. Cela dit, nous serions tout aussi préoccupées par l'éthique d'un déni d'accès à des services de santé privés. Cela ne veut pas dire que nous devrions prendre la décision de faire ça. Ce que cela veut dire, et c'est relié à votre question, c'est qu'on ne peut pas se contenter de dire que, sur le plan éthique, c'est notre choix et, que ça vous plaise ou non, nous allons l'imposer. On devrait être capable de justifier, du point de vue de l'éthique, cette interdiction/prohibition des services de santé privés. Je ne suis pas sûre que nous réussions à le faire à l'avenir.

Il s'agira d'un débat très complexe, d'autant plus que l'éthique de gouvernement sera différente à des niveaux différents.

Quand vous me demandez si l'éthique, c'est simplement ce que je préfère, je vous réponds que non car l'essence même de l'éthique est qu'il ne s'agit pas de préférences. C'est une approche structurée et analytique d'un conflit impliquant des valeurs et des positions différentes. Vous pouvez fort bien parvenir à une réponse totalement différente à la même question, selon la structure éthique que vous utilisez pour votre analyse, mais il vous appartient quand même de justifier votre choix. C'est la justification de ce choix qui fait l'éthique.

Presque toutes ces questions représentent des jugements de valeur, et c'est pourquoi nous avons un conflit. Si nous produisons tous la même réponse, nous aurions ce que nous appelons la «lumière blanche de la sagesse éthique», mais ce n'est pas la réalité.

Le sénateur Keon: Vous avez commencé à répondre à la question que j'allais poser. Au sujet du projet de loi 11, la grande question à laquelle nous sommes tous confrontés concerne l'éthique de tenir une population otage d'un système unique.

Let me give you an example. I am frequently called by people who need a certain procedure that they have been told they cannot have in Canada under general anaesthesia. They want to know where to go in America.

Is it ethical for us to have decided that some apprehensive person cannot have anaesthetic?

Dr. Somerville: The dean at one university wrote to me wanting a copy of a book entitled *Canadian Health Care Policy*. One thing he said in his letter that gave me a shock in the realization of it, was that Canada really does have a private health care system, only it is in the United States, unlike Australia, where it is too far to go to access another system.

I think you are making a very important point. I certainly cannot answer whether it is ethical or not. I could, at some point, try to do an analysis of whether it is ethical to continue to do that.

That is exactly the point I was raising. We cannot simply assume that it is ethical to do that. We have to be able to justify that it is ethical. I do not know whether we are going to be able to do that. It is the issues that Professor Shanner raised.

If your primary value is equality of health care for the Canadian population, you may feel that we should provide for all basic needs and not go beyond that. You could possibly justify it. On the other hand, there is this joke going around in Ontario about a man who booked himself into a veterinary clinic with the last name of Fido because then he got a CT scan the next day, whereas he could not get it in the hospital for several months.

If you can spend your money on your dog, why should you not be able to spend it on yourself, if that is what you want to do? The reasons are societal. There are value reasons. There are social cohesion reasons, and there are community-forming reasons. That is why we have such an incredibly difficult job in doing this.

Dr. Shanner: If I could add, there is a real tension between this level, which is the policy for the community, and the health care providers level, which is at the bedside with individuals. Health care providers are committed to doing the best for the patient, and their job is to move mountains to get that procedure. When it is not available, the clinician is unable to do what is needed, and may be thereby constrained from meeting personal ethical requirements. There is a very difficult level issue already, in that whatever you decide, you must not undermine the ethical commitment of the care providers themselves.

The other piece of this is that allocation decisions are not appropriately made at the bedside; it must be here. By the time an individual says, "I need a procedure but I cannot get it. What will you do for me?", the problem, and the ethical failing, has already occurred.

Je vais vous expliquer ce que je veux dire. Je reçois souvent des appels de gens qui ont besoin d'un certain traitement qu'ils ne peuvent pas obtenir au Canada, leur a-t-on dit, sous anesthésie générale. Ils veulent donc savoir où aller aux États-Unis.

Est-il éthique pour nous de décider que telle ou telle personne ayant une appréhension ne pourra pas obtenir une anesthésie?

Mme Somerville: Un doyen d'université m'a écrit un jour pour obtenir un exemplaire d'un livre intitulé *Canadian Health Care Policy*. Ce qui m'a frappée dans sa lettre, c'est qu'elle m'a amenée à réaliser que le Canada possède en fait un système de santé privé, mais il se trouve qu'il est aux États-Unis, alors que l'Australie n'a pas accès à un autre système parce qu'elle est trop loin.

Votre remarque est très importante. Je ne saurais vous dire si c'est éthique ou non. Je pourrais essayer de faire une analyse pour savoir s'il est éthique de continuer de cette manière.

Mais c'est exactement ce que je voulais dire: on ne peut pas simplement supposer qu'il est éthique d'agir ainsi. On doit être capable de justifier que c'est éthique. Je ne sais pas si nous y arriverons. Cela fait partie des questions posées par la professeure Shanner.

Si votre valeur fondamentale est l'égalité des soins pour toute la population canadienne, vous pouvez dire que notre rôle doit être de répondre à tous les besoins fondamentaux et à rien d'autre. Vous pouvez peut-être justifier cela. Par contre, vous connaissez peut-être la blague qui circule en ce moment en Ontario au sujet d'un homme qui a pris un rendez-vous dans une clinique vétérinaire au nom de Fido parce que cela lui permettait d'obtenir dès le lendemain un tomodensitogramme qu'il n'aurait pas pu obtenir avant plusieurs mois en s'adressant à un hôpital.

Si vous pouvez dépenser de l'argent pour votre chien, pourquoi ne devriez-vous pas pouvoir le dépenser pour vous-même, si c'est ce que vous voulez faire? Les raisons sont d'ordre social. Ce sont des raisons fondées sur des valeurs. Il y a des raisons de cohésion sociale et il y a des raisons de formation de la société. Voilà pourquoi il est aussi incroyablement difficile de répondre.

Mme Shanner: Je me permets d'ajouter qu'il y a une tension sérieuse entre ce niveau, qui est la politique publique pour la société, et le niveau de ceux qui dispensent les soins, qui correspond à la politique pour l'individu. Les personnes qui dispensent les soins sont tenues de faire le mieux possible pour le patient, et leur travail est de déplacer des montagnes pour ce faire. Lorsqu'une procédure n'est pas disponible, le clinicien est dans l'impossibilité de faire ce qu'il devrait et cela risque donc de limiter son aptitude à répondre à ses exigences éthiques personnelles. Il y a un problème d'éthique extrêmement difficile à résoudre car, quoi que l'on décide, on ne doit pas aller à l'encontre de l'engagement éthique de ceux qui dispensent les soins.

L'autre volet de cette équation est que les décisions relatives aux ressources ne peuvent être prises au lit du patient, elles doivent l'être ici. Au moment où l'individu dit: «J'ai besoin d'une opération et je ne peux pas l'obtenir, qu'allez-vous faire pour moi?», le problème s'est déjà posé, et la défaillance éthique aussi.

We need to step back several levels. There are larger questions, and again I do not have answers for them. We need a very serious, community-wide conversation about what are the goals of health care? This affects everything, including how research monies are invested and what kinds of health care problems and technologies we will pursue. Do we expect significant benefit, say, to justify the enormous amounts that we are investing in genetics research? How do we deal with questions about repeated treatments, people with chronic conditions who come back again and again, and who end up using vastly more health care resources than people who are generally healthy but experience the occasional crisis situation?

We have questions about age. How do we deal with neo-natal intensive care? How do we deal with the increasing age of the population demographically? Are we going to institute an age limit beyond which we will not provide care and you are on your own, or do we say it is for all ages? There are limits that need to be imposed. It is not an age question, it is something else. However, what is that something else?

We need your leadership to help answer those questions in the community. Help us with that conversation. When we have to say no, to whom do we say no, and what is the justification? We cannot do everything for everyone.

Dr. Somerville: It is a very real and current problem, as we see if we look at the Supreme Court of Canada's major judgment on informed consent in a case called *Reibl v. Hughes*. There is another one, *Lepp v. Hopp*. Under that, the physician has to tell the patient all the information that would be material to a reasonable person in the same circumstances.

One of the things that is material to patients is knowing the possible range of treatments for what is wrong. Usually the patient questions what is best and what is worse. Physicians, at the moment, are restricted by health care budgets in the hospitals. Sometimes, what would be the best thing to do is not even available.

What does that physician do? A lot of physicians are fudging it and do not say much about it. Legally, quite apart from ethically, that physician is not obtaining informed consent when he or she does that.

I gave a lecture based on this paper the other day, and I had people from the hospitals falling under the table saying, "You mean you want us to tell patients about treatments that would be good for them, but that we cannot give them here?" I said that it was their legal obligation to do so. It is also their ethical obligation. One of these doctors said that it was already tough enough practising medicine, it would be impossible if they had to do that. In fact, that is what they should be doing, and some doctors are. It is very, very difficult.

The Chairman: Senator Carstairs has had an example of that in her family life.

Il faut prendre du recul. Il y a des questions de portée plus globale et, je le répète, je n'ai pas les réponses. Il nous faut avoir un débat très sérieux dans notre société sur ce que sont les buts du système de santé. Cela touche tout, y compris la manière dont les budgets de recherche sont investis et le type de problèmes de santé à résoudre et de technologies à utiliser. Prévoyons-nous des bienfaits importants pour justifier les sommes énormes que nous investissons dans la recherche génétique? Comment traiter des problèmes tels que les traitements à répétition, les malades chroniques qui reviennent constamment et qui finissent par utiliser considérablement plus de ressources que les gens qui sont généralement en bonne santé mais qui tombent malades une fois de temps en temps?

Il y a aussi des questions d'âge. Que faisons-nous pour les soins intensifs néonataux? Comment réagissons-nous au vieillissement de la population? Va-t-on fixer un âge limite au-delà duquel on ne dispensera plus de soins et où les gens devront se débrouiller eux-mêmes? Il y a des limites à imposer. Ce n'est pas une question d'âge, c'est une question d'autre chose, mais quoi?

Nous avons besoin de votre leadership pour amener la société à trouver les réponses à ces questions. Aidez-nous dans ce débat. Si nous devons dire non, à qui devons-nous le dire et pour quelle raison? On ne peut pas tout faire pour tout le monde.

Mme Somerville: C'est un problème très réel et très actuel, comme le montre l'arrêt très important de la Cour suprême du Canada sur la question du consentement éclairé dans l'affaire *Reibl c. Hughes*. C'est un autre *Lepp c. Hopp*. Avec cet arrêt, le médecin est tenu de divulguer au patient toutes les informations qui seraient importantes pour une personne raisonnable placée dans la même situation.

Or, l'une des choses qui sont importantes pour les patients est de connaître toute la gamme de traitements possibles. Généralement, le patient veut savoir ce qui est mieux et ce qui est pire. À l'heure actuelle, la marge de manœuvre des médecins est limitée à cause des budgets des hôpitaux. Parfois, ce qu'il y aurait de mieux à faire n'est même pas disponible.

Que doit faire le médecin dans ce cas? Beaucoup d'entre eux tournent autour du pot et ne disent pas grand-chose. Légalement, et ceci est tout à fait différent de l'éthique, le médecin qui agit ainsi n'obtient pas le consentement éclairé.

J'ai donné une conférence à ce sujet l'autre jour et des employés d'hôpitaux étaient abasourdis de m'entendre dire cela. Ils me disaient: «Vous voulez dire que nous devrions parler aux patients de traitements qui seraient bons pour eux mais que nous ne pouvons pas leur offrir?» J'ai répondu que c'était leur devoir en vertu de la loi, mais aussi en vertu de l'éthique. L'un de ces médecins a dit qu'il était déjà bien difficile d'exercer la médecine aujourd'hui mais que ce serait impossible dans ce contexte. C'est pourtant ce que les médecins devraient faire, et certains le font déjà. C'est un problème très complexe.

Le président: Le sénateur Carstairs en a eu un exemple dans sa famille.

Senator Carstairs: Quite frankly, the doctor was very ethical and said these are the options — radiation, surgery, and therapy. He said that he could not administer therapy in this country for prostate cancer, since it was not available. He outlined all three. When I asked him what would he do if he were in that situation, he said he would have the special therapy. We went to the United States and had that therapy.

Dr. Somerville: I am sitting on the health technology assessment group at Health Canada. We had a meeting last week. There is a new technology out that Dr. Keon will know about. It is an implant device, and theoretically, it could save the life of anybody who has had any kind of heart trouble. One estimate of the cost of giving it to all Canadians who could benefit from it is that it would use between 4 and 5 per cent of our total health care budget — one small technology.

We are dealing with the issues we see on the front pages of our newspapers. These are just the tip of an enormous iceberg.

Dr. Shanner: I will mention one last item to call attention again to issues that Dr. Millar mentioned earlier. All acute care services, everything done in hospitals and most of what is done in doctors' offices, account for about 15 per cent of our health status. If we want to be healthy Canadians, and if we seriously want to reduce how much we spend on our health budget, we will have to work in areas outside that budget. We need to focus on poverty relief, education, cleaning up the environment, and that long list of other social goods that create the conditions in which we experience health or illness.

There is another aspect to this. We should, perhaps, not focus on the patients, for whom wonderful intervention might be available, but we could only provide a few without bankrupting the country. Instead, we should step back and consider not just what is most effective in health care, but also how to keep people out of the acute care system in the first place, while maintaining a robust health care system for crisis situations that were not preventable.

Dr. Somerville: The only thing you can say about that is that maybe we have the wrong terminology when we say "health care," because that focuses on what we are doing about health. Actually, we are talking about illness care. It is, as Susan Sontag says "the kingdom of the well and the kingdom of the sick." We are dealing with how to treat the people in the kingdom of the sick. We get into a mess when we start to bring all these other things into it.

Senator Fairbairn: We could continue for hours on this topic. As I listened to you use key words such as value judgment and trust, another element struck me — how to define ethics or offer ethical protection? There is also the ability of the people to understand the layers in the definition as well. This encompasses all of the additional issues such as poverty and lack of opportunity.

Le sénateur Carstairs: Très franchement, le médecin a fait preuve d'une éthique irréprochable en présentant toutes les options — radiation, chirurgie et thérapie. Toutefois, il a dit qu'il ne pouvait pas offrir de thérapie du cancer de la prostate puisqu'elle n'est pas disponible au Canada. Il avait cependant présenté les trois options. Quand je lui ai demandé ce qu'il ferait s'il se trouvait dans cette situation, il m'a dit qu'il prendrait la thérapie spéciale. Nous sommes donc allés aux États-Unis.

Mme Somerville: Je fais partie du Groupe d'évaluation des technologies de la santé, à Santé Canada, qui s'est réuni la semaine dernière. Il existe une nouvelle technologie, que le docteur Keon connaît; c'est un implant qui, théoriquement, pourrait sauver la vie de quiconque souffre de troubles cardiaques. Selon les estimations, si l'on en faisait bénéficier tous les Canadiens qui le pourraient, cela accaparerait entre 4 p. 100 et 5 p. 100 de notre budget total de la santé — et il s'agit d'une petite technologie.

Voilà des problèmes dont nous prenons connaissance tous les jours dans les journaux. Et ce n'est que la pointe d'un iceberg énorme.

Mme Shanner: Je vais faire une dernière remarque concernant un sujet soulevé par M. Millar. Tous les services de soins aigus, tout ce qui se fait dans les hôpitaux et la majeure partie de ce qui se fait dans les cabinets des médecins, représente environ 15 p. 100 de notre bilan de santé. Si nous voulons être en bonne santé et si nous voulons sérieusement réduire le budget de la santé, il va falloir agir dans des domaines qui se situent à l'extérieur de ce budget. Il va falloir agir contre la pauvreté, pour l'éducation, pour l'environnement et pour toute une longue liste de biens sociaux qui créent des conditions qui agissent sur la santé et la maladie.

Il y a un autre aspect du problème. Nous ne devrions peut-être pas tout concentrer sur les patients, à qui on peut peut-être offrir certaines interventions disponibles mais au prix de mettre la nation en faillite. Au lieu de cela, on devrait peut-être prendre du recul et s'interroger non pas seulement sur ce qui est le plus efficace, du point de vue de la santé, mais aussi sur ce qui peut éviter aux gens d'avoir besoin de systèmes de soins aigus, de façon à préserver un système de soins robuste pour les situations de crise inévitables.

Mme Somerville: La seule chose que l'on peut dire à ce sujet est que nous n'utilisons peut-être pas la bonne terminologie quand nous parlons de «soins de santé», puisque cela évoque immédiatement ce que nous faisons au sujet de la santé alors que nous voulons en fait parler de traitement des maladies. Comme le disait Susan Sontag, c'est «le royaume des bien-portants et le royaume des malades». Ce qui nous occupe, c'est comment traiter les gens du royaume des malades, et c'est quand on y mélange toutes sortes d'autres choses qu'on crée la pagaille.

Le sénateur Fairbairn: Nous pourrions continuer pendant des heures sur ce sujet. En vous écoutant employer des expressions telles que «jugement de valeur» et «confiance», une question m'est venue à l'esprit — comment définir l'éthique ou offrir une protection éthique? Il faut aussi voir dans quelle mesure les gens peuvent comprendre les strates de la définition, ce qui englobe

However, with all the ethics, best practices, and goodwill that we can come up with, we are also looking at a great number of people who will not understand it, except perhaps in the most fundamental way. This is leading to the issue of wellness and illness.

Also, in consideration of what we have gone through and will continue to go through, there is another important issue. At the heart of a lot of the concern, which has come, certainly, in the form of organized demonstrations — people just coming out to express themselves — is there not a question of fear?

Dr. Shanner: Yes.

Senator Fairbairn: It really may be a lack of understanding, knowledge, and ability. There are many people who can use the Internet, as I have myself, and find a vast array of suggested new developments, but there are just as many people, not just in this country but in this world, who have no access to that part of the debate.

Those are my thoughts. The one that always comes through, when it comes to health, is the primal feeling of anxiety and fear, because there is nothing more personal.

Dr. Shanner: I think that you have two really wonderful, rich questions blended together. On the first, about who can understand all of this, there are two things to consider. One encompasses the areas of knowledge — economics, politics, and the outcomes data. Very few people understand much of any of this at all, let alone the whole picture. The second part of this we might call “wisdom,” which has nothing to do with knowledge or power. This is what you learned at grandma’s knee about what is important in life. There is quite a lot of wisdom among those who are not in positions of power, knowledge, or authority. I think that your insight about the fear that arises when health is on the table is both instinctive and entirely reasonable. When your health is at stake, nothing else matters. Everyone pretty much recognizes that.

When we are reasonably healthy, we get distracted and we take our good health for granted. We worry about other things, such as paying bills and advancing in our jobs. It all comes to a screeching stop when we get sick, and suddenly it is very clear just what is important here.

I want to emphasize not only that recognition of the value of health and health care, but also a lot of the core ethical values. I am giving you some technical words here, but they really come down to: Do not pick on people, do not hurt them, do not kill them; and treat other people as you yourself would like to be treated. When you and your little brother shared the piece of cake, you divided it fairly. Help people. There is an understanding of integrity and honesty. If we did not learn this as young children, then I would have nothing to teach. I can only give it a name and call attention to the innate wisdom, or the wisdom learned very early, about what it means to live a good life and be a good person.

toutes les questions additionnelles comme la pauvreté et le manque de possibilités d’emploi. Toutefois, comme pour toute question d’éthique, de meilleures pratiques et de bonne foi, nous avons un grand nombre de gens qui ne comprendront pas, sauf peut-être de la manière la plus élémentaire. C’est ce qui sous-tend les questions de santé et de maladie.

Considérant par ailleurs ce que nous venons déjà de vivre et ce que nous allons continuer de vivre, il y a un autre problème important. Au cœur de cette préoccupation, qui s’est certainement exprimée par des manifestations publiques — des gens sortant dans la rue pour s’exprimer — n’y a-t-il pas une question de peur?

Mme Shanner: Si.

Le sénateur Fairbairn: C’est peut-être en fait un manque de compréhension, de connaissance et de capacité. Beaucoup de gens savent utiliser l’Internet, comme moi, et trouver une foule de renseignements sur toutes sortes de choses nouvelles, mais il y en a tout autant, pas seulement dans ce pays mais aussi à l’étranger, qui n’ont pas accès à cette partie du débat.

Voilà ce que je voulais dire. La chose qui me vient de toute façon toujours à l’esprit, quand on parle de santé, c’est la réaction primale d’angoisse et de peur, car il n’y a rien de plus personnel.

Mme Shanner: Je pense que vous venez de poser d’un seul coup deux questions merveilleuses et riches. Pour la première, c’est-à-dire qui peut comprendre tout ça, il y a deux choses à prendre en considération. L’une englobe les domaines du savoir — économie, politique et données sur les résultats. Très peu de gens comprennent bien de quoi tout cela retourne, sans parler de l’ensemble de la problématique. La deuxième chose, c’est ce que nous pourrions appeler «la sagesse», qui n’a rien à voir avec le savoir ou le pouvoir. C’est ce qu’on a appris sur les genoux de sa grand-mère sur ce qui est vraiment important dans la vie. Il y a en fait énormément de sagesse chez toutes les personnes qui n’occupent pas un poste de pouvoir, de savoir ou d’autorité. Je pense que ce que vous dites au sujet de la peur qui apparaît quand il s’agit de santé est à la fois instinctif et tout à fait raisonnable. Quand la santé est en jeu, plus rien d’autre ne compte. Nous le savons tous.

Quand nous sommes en relativement bonne santé, nous tenons la santé pour acquis et nous parlons d’autre chose. Nous nous occupons de nos factures et de l’évolution de notre emploi. Tout cela s’arrête brutalement dès que nous tombons malades et, d’un seul coup, nous voyons très clairement ce qui est vraiment important.

Je veux souligner cette reconnaissance de la valeur de la santé, mais aussi un ensemble de valeurs éthiques centrales. J’utilise certains mots techniques mais tout se résume en fait à ceci: ne causez pas de tort aux gens, ne leur faites pas de mal, ne les tuez pas, et traitez les autres comme vous aimeriez qu’on vous traite. Quand vous partagiez un morceau de gâteau avec votre petit frère, vous faisiez deux parts égales. Aidez les autres. Faites preuve d’intégrité et d’honnêteté. Si nous n’avions pas appris cela pendant notre enfance, je ne pourrais rien enseigner. Il s’agit de ce que je ne peux appeler que la sagesse innée, ou une sagesse acquise très tôt, qui nous dit ce que c’est que vivre comme une bonne personne.

Those who have utterly no interest in philosophy may have an interest in religion. It is the same concept and is another explanatory system. It is a search for the good and how to make it manifest in our lives. People understand this, although they are very easily distracted.

The other piece, the public fear, again gets back to the process. We are completely vulnerable when we are ill because of fears related to disability or the loss of life. As citizens, we are, in a way, vulnerable to our policy leaders. When the policy leaders are not listening, not taking seriously how anyone else perceives this or experiences that, and decline to discuss the issues relevant to health care providers, then we have a situation where the lack of trust and powerlessness is much greater than in health care itself. I believe that it was the powerlessness and the undemocratic process that were being protested in respect of Bill 11. It is not just about health care in Alberta any more, it is also about whether the government is responsive to the people, and to those who are sworn and committed to help them.

Those are two different issues that are separable but very closely connected. We have seen the connection and the evolution in Alberta very clearly.

Dr. Somerville: I think one of the things that we have to do is look at the changes that have taken place in our society and how those changes are altering the context in which we deliver health care.

For instance, it is often said that our society is based on intense individualism. That means, for example, that with all the talk about rights to personal autonomy and self-determination, the individual's claims are given priority over the claims of the community. If we looked back to when we founded medicare, we might find that there was quite a different balance between community and individualism. We need to look at who the people are. We have seen an incredible increase, in the last 12 months, of cases in our Canadian courts where people have sued somebody to obtain health care. This has happened only recently in the United States as well. We have to ask why that is happening. I think one of the reasons is the baby boomers. They are well educated and articulate, feel that they have rights, and are used to getting what they think they need. There are all sorts of things that we have to look at to see why the situation is different now from what it was when we started medicare, and how that can be accommodated.

The Chairman: Thank you both.

The committee adjourned.

Ceux qui ne prêtent strictement aucun intérêt à la philosophie s'intéressent peut-être à la religion. C'est le même concept, avec une autre grille d'explication. C'est la recherche du bien et de la manière dont on peut le rendre manifeste dans notre vie. Les gens savent de quoi il s'agit, même s'il est très facile de l'oublier.

L'autre élément, la peur publique, nous ramène à nouveau au processus. Nous sommes complètement vulnérables dès que nous tombons malades, à cause de nos craintes d'invalidité ou de décès. À titre de citoyens, nous sommes d'une certaine manière vulnérables face à nos dirigeants. Si ceux-ci ne nous écoutent pas, s'ils ne prennent pas au sérieux la manière dont nous percevons ceci ou vivons cela, et s'ils refusent de discuter des questions qui sont importantes pour ceux qui dispensent les soins, nous nous retrouvons dans une situation où le manque de confiance et l'impuissance sont beaucoup plus grands quand dans le système de santé lui-même. Je pense que c'était l'impuissance et le processus antidémocratique qui étaient à l'origine des protestations contre le projet de loi 11. Il ne s'agissait plus seulement du système de santé de l'Alberta, il s'agissait aussi de la manière dont le gouvernement réagit à la population et à ceux qui ont juré de l'aider.

Il y a là deux questions différentes qui sont séparables mais aussi fort étroitement reliées. Nous avons très clairement vu le lien et son évolution en Alberta.

Mme Somerville: L'une des choses qu'il faut faire, à mon avis, c'est examiner les changements qui se sont produits dans notre société et la manière dont ils modifient le contexte dans lequel nous dispensons les soins de santé.

Par exemple, on dit souvent que notre société est foncièrement individualiste. Cela veut dire, par exemple, avec tout ce qu'on dit du droit à l'autonomie personnelle et à l'autodétermination, que les revendications de l'individu auront priorité sur celles de la collectivité. Si l'on repense à l'époque où l'on a fondé l'assurance-santé, on constatera qu'il y avait peut-être alors un équilibre tout à fait différent entre collectivité et individu. Il faut voir qui sont vraiment les gens. Nous avons constaté au cours des 12 derniers mois une augmentation incroyable du nombre de gens qui intentent des poursuites devant les tribunaux canadiens pour obtenir des soins de santé. La même chose n'est apparue que récemment aux États-Unis aussi. Il faut se demander ce qui se passe. À mon avis, l'une des raisons est que nous sommes dans la période des baby-boomers. Ils ont fait des études, ils savent s'exprimer, ils estiment avoir des droits et ils ont l'habitude d'obtenir ce qu'ils veulent. Il y a toutes sortes de choses à prendre en considération pour comprendre pourquoi la situation actuelle est différente de ce qu'elle était à la création de l'assurance-santé, et voir comment on peut en tenir compte.

Le président: Merci beaucoup.

La séance est levée.



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WITNESSES—TÉMOINS

Wednesday, May 10, 2000

From the University of Western Ontario:

Ake Blomqvist, Professor.

From the University of Toronto:

Colleen Flood, Professor;

Mark Stabile, Professor.

Thursday, May 11, 2000

From the Canadian Institute for Health Information:

John S. Millar, Vice-President, Research and Analysis.

From McGill University:

Margaret Somerville, Professor.

From the University of Alberta:

Laura Shanner, Professor.

Le mercredi 10 mai 2000

De l'Université Western Ontario:

Ake Blomqvist, professeur.

De l'Université de Toronto:

Colleen Flood, professeure;

Mark Stabile, professeur.

Le jeudi 11 mai 2000

De l'Institut canadien d'information sur la santé:

John S. Millar, vice-président, Recherche et analyse.

De l'Université McGill:

Margaret Somerville, professeure.

De l'Université de l'Alberta:

Laura Shanner, professeure.



Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

*Proceedings of the Standing
Senate Committee on*

*Délibérations du comité
sénatorial permanent des*

Social Affairs, Science and Technology

Affaires sociales, des sciences et de la technologie

Chairman:
The Honourable MICHAEL KIRBY

Président:
L'honorable MICHAEL KIRBY

Wednesday, May 17, 2000

Le mercredi 17 mai 2000

Issue No. 15

Fascicule n° 15

Tenth meeting on:
The state of the health care system in Canada.

Dixième réunion concernant:
L'état du système de santé au Canada

WITNESS:
(See back cover)

TÉMOIN:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Beaudoin	Gill
* Boudreau, P.C. (Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Pépin
Cook	Robertson
Corbin	

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Corbin substituted for that of the Honourable Senator Fairbairn, P.C. (*May 15, 2000*).

The name of the Honourable Senator Pépin substituted for that of the Honourable Senator Banks (*May 15, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Beaudoin	Gill
* Boudreau, c.p. (ou Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Pépin
Cook	Robertson
Corbin	

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Corbin substitué à celui de l'honorable sénateur Fairbairn, c.p. (*le 15 mai 2000*).

Le nom de l'honorable sénateur Pépin substitué à celui de l'honorable sénateur Banks (*le 15 mai 2000*).

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, May 17, 2000

(22)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 3:52 p.m., the Chairman, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Callbeck, Carstairs, Cook, Keon, Kirby, LeBreton and Robertson (7).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Julie MacKenzie.

Also in attendance: The official reporters of the Senate.

WITNESS:

As an individual:

The Honourable Marc Lalonde, P.C.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see Proceedings of the Committee, Issue No. 8.*)

The Chairman made a statement.

Mr. Lalonde made a statement and answered questions.

At 17:35 p.m., the committee adjourned to the call of the Chair.

ATTEST:

PROCÈS-VERBAL

OTTAWA, le mercredi 17 mai 2000

(22)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui dans la pièce 705 de l'édifice Victoria, à 15 h 52, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Callbeck, Carstairs, Cook, Keon, Kirby, LeBreton et Robertson (7).

Également présentes: Du Service de recherche de la Bibliothèque du Parlement: Odette Madore et Julie MacKenzie.

Aussi présents: Les sténographes officiels du Sénat.

TÉMOIN:

À titre personnel:

L'honorable Marc Lalonde, c.p.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale sur l'état du système de santé au Canada. (*Le texte complet de l'ordre de renvoi figure dans les délibérations du comité, fascicule n^o 8.*)

Le président fait une déclaration.

M. Lalonde fait une déclaration puis répond aux questions.

À 17 h 35, la séance est levée jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

EVIDENCE

OTTAWA, Wednesday, May 17, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 3:52 p.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Senators, we are here to continue our investigation into the state of the health care system in Canada and what the federal role should be and how that role should be changed for the future to keep the system sustainable. We are delighted to have with us today as our witness Marc Lalonde, whom I think all of you know from a variety of jobs he has had in the past in both the private and public sectors.

Mr. Lalonde was the minister of health in 1977 when the method of the federal government's financial contribution to health care was changed from a 50-50 cost share formula. Prior to 1977, the federal government paid 50 per cent of an agreed set of health care costs between the federal government and the provinces. The formula was changed in 1977 under an act called the Established Programs Financing Act and moved to block funding. That is lump sum funding, not a direct cost-shared funding. It also moved to transfer part of that block funding to include not only cash but also so-called tax points. Mr. Lalonde may want to comment on that. We thought it would be important to understand the logic of that change since the tax point is hot in the sense of whether the federal government should still count it.

In addition, we will use this opportunity to talk about the issue of the management of major hospitals. For 14 years, Mr. Lalonde was the chairman of the board of a major hospital in Montreal. I think understanding that perspective of the health care system would also be helpful.

Finally, since he was minister of health at the time ParticipAction and other programs were started that were driven towards improving the health of Canadians, he might want to comment on that as well.

Mr. Lalonde does not have a written opening statement because he came in on a plane from England last night.

We thank you for being here, Mr. Lalonde. You know our format. Unlike the House of Commons, the questions will not be partisan, but they may be substantive. Please proceed.

[*Translation*]

The Honourable Marc Lalonde, P.C.: Honourable senators, I would like to begin by thanking you for your invitation. As the chairman has just explained, I for many years had to deal with health-related issues. During the last five years, my role has mostly been that of patient within our hospital system, and there is absolutely no doubt in my mind that it is thanks to this system that I am still on this earth and able to appear before you today.

TÉMOIGNAGES

OTTAWA, le mercredi 17 mai 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit ce jour à 15 h 52 pour examiner l'état du système de soins de santé au Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Sénateurs, nous poursuivons notre étude du système de santé canadien et de ce que devrait être le rôle fédéral et de l'évolution à imprimer à celui-ci pour que le système reste viable à l'avenir. Nous sommes ravis d'entendre aujourd'hui Marc Lalonde, que vous connaissez certainement tous de par les diverses fonctions qu'il a exercées tant dans le secteur privé que le secteur public.

M. Lalonde était le ministre de la Santé en 1977 lorsque la contribution financière fédérale pour la santé a cessé d'être un partage des coûts moitié-moitié. Avant 1977, le gouvernement fédéral payait 50 p. 100 d'un ensemble convenu de soins de santé. Cette formule a été modifiée en 1977 par la Loi sur le financement des programmes établis, en faveur d'un financement global. Il s'agit là d'un financement forfaitaire, qui n'est plus axé sur le coût. Ce transfert global ne comprenait plus seulement des versements en espèces mais aussi ce que l'on appelle des points fiscaux. M. Lalonde voudra peut-être nous en expliquer les raisons. Nous avons pensé qu'il serait important de comprendre la logique de ce changement, étant donné la controverse entourant les points fiscaux et la question de savoir si le gouvernement fédéral devrait toujours les comptabiliser.

Nous saisissons également cette occasion pour parler de la gestion des grands hôpitaux. En effet, M. Lalonde a été pendant 14 ans le président du conseil d'administration d'un grand hôpital de Montréal. Je pense qu'il nous serait utile de bénéficier de cette perspective sur le système de santé.

Enfin, puisqu'il était ministre de la Santé au moment où ParticipAction et d'autres programmes ont été lancés en vue d'améliorer la santé des Canadiens, il voudra peut-être nous dire également quelques mots à ce sujet.

M. Lalonde n'a pas de déclaration liminaire écrite car il est rentré d'Angleterre seulement hier soir.

Nous vous remercions d'être venu, monsieur Lalonde. Vous connaissez notre façon de procéder. Contrairement à ce qui se passe à la Chambre des communes, nos questions ne seront pas partisans, et porteront sur le fond du problème. Vous avez la parole.

[*Français*]

L'honorable Marc Lalonde, c.p.: Honorables sénateurs, je tiens à vous remercier de votre invitation, et comme le président vient de l'indiquer, j'ai eu à fricoter dans le domaine de la santé durant un grand nombre d'années. Au cours des cinq dernières années, mon rôle s'est surtout concentré dans la fonction de patient dans notre régime hospitalier, et il ne fait aucun doute dans mon esprit que c'est à ce système que je dois de me retrouver encore vivant pour comparaître devant vous aujourd'hui.

It would obviously require more than 10 minutes to describe to you the conclusions I have drawn from my various experiences of the last 28 years. If I had the honour to exert some influence on the evolution of Canada's health policy between 1972 and 1984, since 1984, my experience has been mainly limited to the Quebec scene.

The chairman told you of the main reason for my appearance before the Committee, namely the Established Programs Act of 1977. I was also asked to deal with the Canada Health Act of 1984. I saw that I was to have appeared with my former colleague, Madam Bégin, who was unfortunately not available today, and she clearly would have been in a much better position than me to speak to you about this Act. Since I was Finance Minister at the time of the passage of the Act, I obviously took a professional interest in it, not only as Minister of Health, but also as Minister of Finance.

I will not waste time repeating the content of the Established Programs Act of 1977, the chairman having already summarized it for you today and several previous witnesses having, I believe, already abundantly dealt with it.

I am pleased to see at least two of my former colleagues, senator Callbeck and senator Robertson, who were on the other side of the table when I was Minister of National Health and Welfare. These senators must certainly have a very vivid recollection of the discussions held at the time. The chairman even stated that he was at the time a high ranked official at Privy Council and that he had strongly opposed, thankfully unsuccessfully, the passage of the 1974 Act. This goes to prove that it is wrong to think that officials always have the upper hand on ministers.

I would like to begin by saying a few words about the context preceding passage of the 1974 Act. At the time, it was the Department of National Health and Welfare. It covered virtually all the social and health care programs of the Canadian government. It was a time when the Health Minister covered approximately a third of all federal expenditures. In 1972, the Department was co-managed by two deputy-ministers: Mr. A. W. Johnson for Welfare and Dr. Maurice Leclerc for Health.

Following my appointment in 1972, we decided to undertake an in-depth review of the programs the Department was responsible for. In 1972, we published the orange book on Canadian social security reform and 1974 saw the publication of a document entitled, "A New Perspective on the Health of Canadians." This latter publication has been tabled with the committee and I will come back to it in detail later.

One of the main conclusions of these studies carried out in parallel by both branches of the Department was that it was essential to broaden the concepts that had led to the establishment of the welfare and health systems in Canada. Furthermore, the definitions contained in the existing federal legislation were creating certain problems that had to be dealt with.

De toute évidence, j'aurais besoin de plus de 10 minutes pour vous décrire les conclusions de mes diverses expériences au cours des 28 dernières années. Si j'ai eu l'honneur d'avoir une certaine influence sur l'évolution de la politique canadienne en matière de santé, entre 1972 et 1984, mon expérience est maintenant beaucoup plus limitée à la scène québécoise depuis 1984.

Le président vous a indiqué l'objet principal qui a motivé ma comparution devant ce comité, à savoir la Loi sur les programmes établis de 1977. On m'avait aussi demandé d'être disponible pour traiter de la Loi canadienne sur la santé de 1984. J'ai noté que je devrais comparaître avec mon ex-collègue, Mme Bégin, qui ne peut malheureusement être disponible aujourd'hui, et il est clair qu'elle aurait été beaucoup plus en mesure que moi de témoigner adéquatement sur cette loi. Comme j'étais ministre des Finances à l'époque où cette loi fut adoptée, il est évident que j'y avais pris un intérêt professionnel, non seulement en tant que ministre de la Santé, mais aussi en tant que ministre des Finances.

Je ne perdrai pas de temps à vous répéter le contenu de la Loi sur les programmes établis de 1977, le président vous en a déjà fait un résumé aujourd'hui et je crois comprendre que plusieurs témoins y ont fait abondamment référence dans les réunions antérieures.

Je constate avec plaisir qu'au moins deux de mes anciens collègues, les sénateurs Callbeck et Robertson, étaient de l'autre côté de la table alors que j'étais ministre de la Santé nationale et du Bien-être social. Ces sénateurs doivent avoir des souvenirs assez vifs des discussions que nous avons eues à l'époque. Le président a même déclaré qu'il était haut fonctionnaire au Conseil privé à cette époque et qu'il s'était vivement opposé, heureusement sans succès, à l'adoption de la loi de 1974. Ce qui indique qu'il est faux de prétendre que les fonctionnaires ont toujours le dessus sur les ministres dans l'administration fédérale.

J'aimerais d'abord dire un mot sur le contexte qui a précédé l'adoption de la loi de 1974. À l'époque, il s'agissait du ministère de la Santé nationale et du Bien-être social. Il regroupait presque tous les programmes sociaux du gouvernement canadien et les programmes de santé. C'était une époque où le ministère de la Santé couvrait environ le tiers des dépenses fédérales dans leur ensemble. En 1972, le ministère était dirigé parallèlement par deux sous-ministres: M. A. W. Johnson pour le bien-être social et le docteur Maurice Leclerc pour la santé.

Suite à ma nomination en 1972, nous avons décidé de faire une revue en profondeur des programmes dont le ministère était responsable. Il y a eu la publication, en 1972, du livre orange sur la réforme de la sécurité sociale canadienne et, en 1974, la publication d'un document intitulé: «Nouvelles perspectives de la santé des Canadiens.» Ce dernier vous a d'ailleurs été remis. J'y reviendrai plus en détails.

Une des conclusions fondamentales de ces études menées en parallèle par les deux branches du ministère était à l'effet qu'il était essentiel d'élargir les concepts qui avaient mené à l'adoption des régimes de bien-être social et de santé au Canada. De plus, les définitions contenues dans les lois fédérales en vigueur créaient plusieurs problèmes que nous devons surmonter.

At the time, the provinces had been complaining for several years. In my opinion, these complaints were for the most part justified by the fact that the application of the systems in place, both in the area of welfare and in that of health care, were an excessive intrusion of the federal government in areas under provincial jurisdiction. Furthermore, this federal system imposed too much rigidity and too many distortions in the distribution of financial resources in these areas.

Let me say a few words about the indubitable rigidities that existed. We were confronted with increasing costs in the areas of health and welfare during a period of stagflation, in other words, a stagnating economy and high inflation. The federal government wanted to contain costs and ensure greater equity between the provinces with regard to the contributions made. Some of the more well-off provinces had the means to support more generous programs that the federal government had to contribute 50 per cent to. Furthermore, the pressures aimed at containing costs had led us to a very strict regulation of the programs and of what was considered an eligible expenditure, both in the area of health and in that of welfare.

If the subject interests you, you could ask your researchers to dig up the rules in force at the time in the areas of health and welfare, and you will see to what extent federal regulation was detailed and how much debate there was with each province. You could thus see, for example, what type of bed was eligible or what type of welfare situation led to 50 per cent federal participation.

Furthermore, the provinces were arguing, and with reason. We were in agreement that the system in place discouraged innovation and concentrated resources in the most costly areas, namely health, hospital insurance and medical insurance. As a matter of fact, the purpose of the hospital insurance program in the 50's and medical insurance in the 60's was to guarantee to all Canadians basic hospitalization and medical care services. At the time, these two services were considered to be costly. The provinces and the federal government had agreed to a 50-50 cost sharing arrangement for these major programs.

Over time, we realized that this concept of health care was rather narrow and that there was a less costly alternative to hospitalization for a good many types of treatment. Unfortunately, this alternative was not eligible for cost sharing with the federal government. When the provincial Ministers of Health and Finance had the choice between a service for which the federal government would pay 50 per cent of the cost and another for which the province would have to pay 100 per cent, it is easy to imagine what the provinces' preference was, even if it was not, objectively speaking, the most efficient investment in terms of the benefits for health care programs.

The Government of Quebec wanted to set up local community service centres to take the overflow from the hospitals, promote less specialized services and improve accessibility. It however

Il y avait à cette époque des plaintes répétées des provinces depuis plusieurs années. À mon avis, ces plaintes étaient en bonne partie justifiées par le fait que l'application des régimes en vigueur, tant dans le domaine du bien-être social que dans celui de la santé, représentait une intrusion excessive du gouvernement fédéral dans des matières de juridiction provinciale. De plus, ce régime fédéral imposait des rigidités trop grandes et des distorsions dans l'allocation des ressources financières dans les secteurs concernés.

Laissez-moi dire un mot sur les rigidités indubitables qui existaient. Nous faisons face à une augmentation des coûts dans les domaines de la santé et du bien-être social dans une période de stagflation, c'est-à-dire de stagnation économique et d'inflation considérable. Le gouvernement fédéral désirait contenir les coûts et assurer une plus grande équité dans les contributions entre les provinces. Certaines d'entre elles, beaucoup plus à l'aise, pouvaient se permettre des programmes plus généreux auxquels le gouvernement canadien était forcé de contribuer à 50 p. 100. Par ailleurs, les pressions pour contenir les coûts nous amenaient à une réglementation pointilleuse des programmes, à savoir ce qui constituait une dépense éligible tant dans le domaine de la santé que dans celui du bien-être social.

Si le sujet vous intéresse, vous pourrez demander à vos chercheurs de récupérer les règlements en vigueur à l'époque dans les domaines de la santé et du bien-être social afin de voir à quel point la réglementation fédérale était détaillée et combien on avait de débats avec chaque province. Par exemple, à savoir si tel genre de lit était admissible ou si telle situation de bien-être donnait ouverture à une participation du fédéral à 50 p. 100.

En outre, les provinces argumentaient aussi avec raison. Nous étions d'accord que le régime en force décourageait l'innovation et concentrait les ressources dans des domaines plus coûteux comme la santé, l'assurance-hospitalisation et l'assurance médicale. D'ailleurs, l'objectif du programme pour l'assurance-hospitalisation dans les années 50 et pour l'assurance médicale dans les années 60 était d'assurer à tous les Canadiens ces services de base qu'étaient l'hospitalisation et les soins médicaux. À cette époque, ces deux services étaient considérés coûteux. Les provinces et le gouvernement fédéral avaient convenu qu'ils s'engageaient à participer à 50 p. 100 dans les coûts de ces programmes majeurs.

Avec le temps, on s'est aperçu que cette conception des soins de santé était plutôt étriquée et qu'il y avait une alternative moins coûteuse que l'hospitalisation pour bon nombre de traitements. Malheureusement, cette alternative n'était pas éligible à la participation aux coûts par le gouvernement fédéral. Lorsque les ministres de la Santé et les ministres des Finances provinciaux avaient le choix entre un service pour lequel le gouvernement fédéral paierait 50 p. 100 des coûts et un autre pour lequel la province devrait en payer 100 p. 100, il n'était pas difficile d'imaginer la préférence de la province, même si ce n'était pas, objectivement, l'investissement le plus efficace en termes de bénéfices pour les programmes de santé.

Le gouvernement du Québec voulait mettre sur pied des centres locaux de services communautaires pour dégorger les hôpitaux, favoriser des services moins spécialisés et plus accessibles à la

found itself in a situation where it was forced to absorb 100 per cent of the costs. The aim was if not to reduce the cost per unit, at least to broaden the services offered to the population.

That was the situation you had in the provinces. As for the federal government, you had another concern. Following publication of the orange book on welfare and the white book on health, we had come to the conclusion that we had to broaden our concept of services in this area. There was also greater and greater concern in the Department of Finance and in the government in general. We were stuck with paying 50 per cent of what the provinces wanted to spend in the areas covered, without having any say at all on the allocation of funding by the provincial governments. There was at the time a great desire for predictability of the federal government's obligations, both in the area of health and in that of welfare.

We wanted to alter the course. Negotiations with the provinces were undertaken and they led to an agreement on a new system that was embodied in the 1977 Act.

On the one hand, we had established greater flexibility for the provinces in the allocation of funding for welfare and health. On the other, we had obtained greater predictability of federal expenditures since we were establishing a per capita payment program that was tied in with the growth of the GNP. These payments were partly in the form of tax points and partly in the form of cash transfers to the provinces.

There is absolutely no doubt that the 1977 Act allowed the Canadian government and provincial governments to reach the two objectives they had been pursuing. I wish to emphasize that the intent at the time was not to reduce the federal contribution to the services already covered, but it is obvious that subsequent events proved that it was perhaps easier for the federal government to do this under the 1977 program than previously.

You asked me to comment on certain disadvantages, and some of these have already been mentioned here. It was obviously more difficult to evaluate the specific federal contribution to each program since you had payments covering a group of programs and since there was no specific allocation, contrary to what had previously been the case, to medical insurance.

Without a doubt this brought about a certain reduction of the political visibility of the federal government's contribution. In my opinion, this could very well have been counteracted by better more aggressive and more systematic information provided by the federal government as to its contribution to provincial programs.

There is a third disadvantage, perhaps the most serious one, that was a concern of ours at the time. There had been a lot of debate surrounding this and our fear was that the establishment of such a system might lead to a decrease in the political commitment of the government and of Canadian parliamentarians towards these

population. Il faisait cependant face à une situation où il lui fallait absorber 100 p. 100 de ces coûts. L'objectif était sinon de réduire les coûts par unité, au moins d'élargir les services à la population.

Vous aviez cette situation du côté des provinces. Du côté du gouvernement fédéral, vous aviez une autre inquiétude. Suite à la publication du livre orange sur le bien-être social et du livre blanc sur la santé, on était venu à la conclusion qu'il fallait élargir notre conception des services dans ce domaine. Il y avait aussi une inquiétude de plus en plus grande de la part du ministre des Finances et du gouvernement en général. Nous étions pris à payer 50 p. 100 de ce que les provinces voulaient dépenser dans les domaines couverts sans avoir quoi que ce soit à dire sur l'allocation de ces dépenses par les gouvernements provinciaux. Il y avait alors un désir de grande prévisibilité dans les obligations du gouvernement fédéral, tant dans le domaine de la santé que dans celui du bien-être social.

On a voulu donner un coup de barre. Des négociations ont eu lieu avec les provinces qui ont mené à un accord sur le nouveau régime qui a été incarné par la loi de 1977.

D'une part, nous avons atteint une plus grande flexibilité pour les provinces dans l'allocation des sommes versées dans le domaine du bien-être et de la santé. D'autre part, nous obtenions une plus grande prévisibilité des dépenses fédérales puisque nous établissions un programme de paiements per capita qui était en relation avec la croissance du PNB. Ces versements prenaient en partie la forme de points d'impôt et en partie celle de versements comptants aux provinces.

Il ne fait aucun doute que la loi de 1977 a permis au gouvernement canadien et à celui des provinces d'atteindre les deux objectifs qui étaient poursuivis. Je tiens à souligner que l'intention à l'époque n'était d'ailleurs pas de réduire la contribution fédérale aux services déjà couverts, mais il est évident que les événements subséquents ont démontré qu'il était peut-être plus facile pour le gouvernement fédéral de le faire en vertu du programme de 1977 qu'antérieurement.

Vous m'avez demandé de commenter quelques inconvénients et parmi ces inconvénients, certains vous ont déjà été mentionnés. Il était plus difficile, évidemment, d'évaluer spécifiquement la contribution fédérale à chaque programme puisque vous aviez des versements qui couvraient un ensemble de programmes et qu'il n'y avait pas une allocation spécifique comme antérieurement, à l'assurance médicale.

Sans aucun doute, il en est résulté une certaine réduction de la visibilité politique de la contribution fédérale. À mon avis, ceci aurait fort bien pu être compensé par une meilleure information, une information plus agressive, plus systématique, provenant du gouvernement fédéral quant à sa contribution aux programmes provinciaux.

Il y a un troisième inconvénient, peut-être le plus grave, qui nous a préoccupés à l'époque. Nous avons beaucoup débattu à ce sujet et notre inquiétude était à l'effet que l'adoption d'un tel régime pourrait mener à une réduction de l'engagement politique du gouvernement et des parlementaires canadiens envers ces

programs if the link between the programs and the federal government's financial contribution was to become more and more vague.

Indeed, why would a federal MP vote in favour of the granting of funds that he or she would not be able to take credit for in any specific way in the eyes of his or her constituents? If he has the choice between offering a specific program about which he or she can say: "Here, the federal government is funding 100 per cent of this program" and a program where one gets lost in the maze of federal-provincial relations and funding allocation determined by the provincial government, it is obvious that the politician's natural tendency will be to lean towards what he or she can draw more credit from.

I believe that this factor did perhaps indeed facilitate the decisions of subsequent Canadian governments to make deep cuts in federal contributions to health and welfare. I will not talk about the 1984 Act because I am running out of time. We could perhaps come back to my views on the present system during the question period.

If I have a piece of advice to give the committee, and it is this: take the broadest possible view of the matter you are studying. Each time there is talk of a crisis in the area of health, people pounce on those questions dealing with the operation and funding of medical and hospital services. That is quite understandable since that is where most expenditures are made.

But if we want to improve the health of Canadians, these two sectors are but elements of a much broader picture that includes other elements that are no less important.

When I look at some of the debates going on now, I am tempted to make a comparison with the automobile industry. A few years ago, we had cars that left a lot to be desired quality-wise. One of the solutions envisaged was to build more garages, more service stations and more body shops. In this way, we would have ensured that all cars be able to be repaired when they fell apart in our hands.

We as a matter of fact saw the arrival on the market of better quality cars. Consumers had complained to such an extent that competition forced car manufacturers to improve the quality of their cars considerably. Then came government regulation, that forced the respect of certain standards, thus improving the quality of automobiles. Then came the realization that it was necessary to improve the quality of roads and to regulate speed.

Coming back now to the issue of health, I remember the anecdote of the lifeguard who spent all of his time pulling people who were drowning from the river. He asked why no one was there to warn people that if they went on the bridge, they risked falling into the river and drowning. It was a faulty bridge, without guard rails and it was falling apart.

programmes, dans le cas où les liens entre les programmes et la contribution financière fédérale devenaient plus vagues.

En définitive, pourquoi un député fédéral voterait-il des fonds pour lesquels il n'est pas en mesure de réclamer crédit devant ses électeurs d'une façon spécifique? S'il a le choix entre l'application un programme spécifique dans lequel il pourra dire: «Voici, c'est le gouvernement canadien qui vous donne 100 p. 100 de tel programme» et un programme où il se perd dans des relations fédérales-provinciales et des allocations déterminées par le gouvernement provincial, il est évident que la tendance naturelle de l'homme ou de la femme politique sera d'aller vers ce sur quoi il peu réclamer le plus de crédit.

Je pense que ce facteur a pu, en effet, rendre plus facile l'adoption des décisions qui ont été prises par les gouvernements canadiens subséquents en vue de couper assez profondément dans les contributions fédérales aux domaines de la santé et du bien-être. Je ne parlerai pas du domaine de la loi de 1984 parce que mon temps s'écoule. On reviendra à mon point de vue sur le régime actuel suite aux questions qui seront soulevées tantôt.

Si j'avais un conseil à donner devant ce comité, ce serait de vous dire de prendre la vue la plus large possible du sujet que vous étudiez. Chaque fois qu'on parle de crise dans le domaine de la santé, on se précipite sur les questions ayant trait au fonctionnement et au financement des services médicaux et hospitaliers. Cela est fort compréhensible puisque c'est là où se font les grandes dépenses.

Si nous désirons améliorer la santé des Canadiens, ces deux grands secteurs ne sont que de simples éléments d'un tableau beaucoup plus large et qui comporte des éléments non moins importants.

Quand je vois certains débats à l'heure actuelle, je suis tenté de faire une comparaison avec l'industrie de l'automobile. Il y a quelques années, on avait des automobiles dont la qualité laissait beaucoup à désirer. Une des solutions envisagées était de construire davantage de garages, de stations-service et d'ateliers de réparation. On aurait donc pu ajouter faire en sorte que toutes les automobiles auraient pu être réparées quand elles nous tombaient entre les mains.

On a par ailleurs vu l'arrivée sur le marché d'automobiles de meilleure qualité. Les consommateurs ont suffisamment protesté que la concurrence a forcé les fabricants à améliorer considérablement la qualité de leur automobile. Par la suite, il y a eu de la réglementation gouvernementale qui est intervenue pour forcer l'adoption de certaines caractéristiques qui ont amené une amélioration de la qualité des automobiles. En outre, on a vu qu'il était nécessaire d'améliorer la qualité des routes et de réglementer la vitesse.

Si je reviens au domaine de la santé, je me rappelle l'anecdote du sauveteur qui passait son temps à retirer des corps en train de se noyer dans une rivière. Il se demandait pourquoi personne n'était sur place pour prévenir les passants qu'ils ne devraient pas s'aventurer sur le pont sans grands risques de tomber dans la rivière et de se noyer. C'était un pont défectueux, sans garde-fous, il était en train de s'effondrer.

That is similar to what we did in 1974 with the New perspective on the health of Canadians. We had identified four main factors in the health of Canadians, namely human biology, life styles, the environment and health care services. We had come to the conclusion that as far as cost-benefits were concerned, health care services were not the factor most likely to improve the health and longevity of Canadians.

When the document came out, it fell like a stone, but it was taken up in the United States by the World Health Organization. As is usually the case, Canadians, after hearing so much talk about it in other countries, starting telling themselves that they were perhaps on to something. The study had a tremendous impact on Canadian policies, both federal and provincial.

The Department of Health carried out much more refined studies on the issue. I noted that the Department recently published a new list of determining factors for health. There are nine of them: income and social status, social support networks, the level of education, one's job and working conditions, the physical environment, the person's biological and genetic baggage, habits and one's ability to adapt, healthy development in childhood and, finally, in ninth place, health services.

We might come back to this later if you are interested. In essence, these nine factors are developments of the four we had identified in 1974 and they constitute important instruments for analysis.

I spent the last two weeks in Washington, before going to England, and I read a series of articles in the *Washington Post* on one of the problems facing Americans today: the problem of obesity. I read that approximately 60 per cent of Americans presently suffer to some degree or other from obesity and that in the schools it has become extremely difficult to get students to exercise and to stay in shape.

Indeed, everyone sees it: all you have to do is go to a beach in the United States in the summer and you see that there is a serious problem somewhere. We are all aware of the grave consequences of obesity, especially for young people. There are two possible solutions: the first is to wait until these people become seriously ill and go to the hospital or to their doctor and require all sorts of costly services, and the second is to tackle the problem with a large-scale public education program. Such a program would target both physical education and eating habits. To quote the Latin of my childhood, *Mens sana in corpore sano*.

This implies the participation of the federal government, the provinces, the schools, the municipalities and the families. The impact on health could be tremendous. If we do nothing, the negative impact will also be tremendous and we will pay for it with health care costs.

C'est un peu ce que nous avons fait en 1974 avec une nouvelle perspective sur la santé des Canadiens. Nous avons identifié quatre facteurs fondamentaux dans la santé des Canadiens, à savoir la biologie humaine, le style de vie, l'environnement et les services de santé. Nous en étions venus à la conclusion qu'en termes de coûts- bénéfices, les services de santé ne constituaient pas le facteur le plus susceptible d'améliorer le niveau de santé et la longévité des Canadiens.

À sa sortie, ce document est un peu tombé comme une roche mais il a été repris aux États-Unis par l'Organisation mondiale de la santé. Comme à l'habitude, les Canadiens, à force d'en entendre parler à l'étranger, se sont dit qu'ils avaient peut-être quelque chose d'intéressant. Cette étude a eu beaucoup d'impact sur les politiques canadiennes, tant fédérales que provinciales.

Le ministère de la santé a poursuivi des études beaucoup plus raffinées sur le sujet. Je constatais que le ministère a récemment publié une nouvelle liste des déterminants de la santé. Ils en ont énuméré neuf qui sont le revenu et la situation sociale, les réseaux de soutien social, le niveau d'instruction, l'emploi et les conditions de travail, les environnements physiques, le patrimoine biologique et génétique, les habitudes de vie et les compétences d'adaptation personnelle, le développement sain dans l'enfance et finalement, en neuvième place, les services de santé.

On pourra y revenir si la chose vous intéresse. Dans le fond, ces neuf facteurs sont des élaborations des quatre que nous avons identifié en 1974 et ils constituent des instruments d'analyse importants.

J'étais à Washington durant les deux dernières semaines, avant d'aller en Angleterre, et je lisais dans le *Washington Post* une série d'articles sur un des problèmes auxquels les États-Unis font face à l'heure actuelle, et qui s'appelle l'obésité. On pouvait y lire qu'environ 60 p. 100 des Américains souffrent à l'heure actuelle d'une forme plus ou moins accentuée d'obésité et qu'il était devenu, dans les écoles, extrêmement difficile d'encourager les étudiants à faire de l'exercice et à se tenir en forme de façon générale.

En effet, tout le monde peut constater cela, il suffit d'aller sur une plage aux États-Unis en été ou dans la saison chaude, et on peut constater qu'il y a un sérieux problème quelque part. On connaît toutes les conséquences négatives du phénomène d'obésité, à partir des jeunes en particulier. Il y a deux solutions possibles: la première est d'attendre que ces gens soient sérieusement malades et qu'ils se présentent à l'hôpital ou chez le médecin, et qu'ils requièrent toutes sortes de services coûteux, ou bien la deuxième serait de s'adresser à cette question par un énorme programme d'éducation populaire. Ce programme devrait traiter à la fois du conditionnement physique et de l'alimentation. Pour citer le latin de mon enfance: *mens sana in corpore sano*.

Ceci implique la participation du gouvernement fédéral, des provinces, des écoles, des municipalités et des familles. L'impact sur la santé pourrait être énorme. Si on ne fait rien, l'impact négatif aussi sera énorme et on aura à payer en termes de coûts de santé.

This is just one example among many others. Experiments carried out over the last 25 years have shown that specific action for promotion and prevention in the area of health can produce rapid and significant effects.

It is to my mind critically important that the issue of health be examined in a broad context. I believe this is neither getting ahead of ourselves and losing our grip on the situation nor an alternative to the offering of top quality and efficient health care services.

Second, such an approach, by the federal government, would have consequences for the federal financial contribution. I believe that it would be a mistake to simply come back to a ceiling on the federal contribution to hospital care and medical services.

Third, in this area, and this is appropriate for the Senate, it is important to understand that the best solutions will be those that will bring about long term action. Even if some of the moves that might be made may have an immediate impact, we must avoid simply patching up the holes and rather look at the situation in its entirety.

[English]

The Chairman: Thank you very much, Mr. Lalonde. I understood your argument for block funding, that is to say, lump sum rather than cost sharing, because I agree with you about the rigidity. The block funding bothered me much less than the tax points. You talked about political credit. It seems to me that it is difficult for a government to get political credit when they have not suffered the political pain of doing the taxing. Giving away tax points really means that the individual taxpayer pays less to one government and more to the other, but they still pay the same amount. That is essentially how we did the tax point transfer.

My view has been that that is what decreased the legitimacy of the role of the federal government; it was not so much the block funding. That leads me to ask whether or not the Canada Health Act should simply be perceived as a way of the federal government getting back legitimacy that it gave up when it gave up tax points. In other words, it said, "Our only real legitimacy is the cash portion, so we better pass an act so that Canadians think we care about the health care system." I am deliberately putting it in an extreme way to set up the issue, but would you comment on the tax point question and legitimacy of the Canada Health Act once you have given away the tax points?

Mr. Lalonde: First, the transfer of tax points was not new in 1974. We did it in Quebec with post-secondary education a long time before 1974. Fundamentally, it was a political settlement with the provinces. We bought our peace at a certain cost, no doubt.

The issue was very politically important in Quebec in particular, but provinces generally felt that the federal government was spending money in what were recognized as provincial

Je cite cet exemple parmi beaucoup d'autres. Il y a d'ailleurs des expériences dans les 25 dernières années qui ont montré qu'une action spécifique dans le domaine de la promotion et de la prévention dans le domaine de la santé peut avoir des effets assez rapides et significatifs.

L'importance d'étudier la question de la santé dans un contexte large m'apparaît majeure. Je soutiens que ce n'est pas une fuite en avant, ni une alternative à la fourniture de services de santé de première qualité et de services efficaces.

Deuxièmement, une telle approche, pour le gouvernement fédéral, a des conséquences pour la contribution financière fédérale. Je pense que simplement revenir à une limitation de la contribution fédérale aux services d'hospitalisation et aux services médicaux serait une erreur.

Troisièmement, dans ce domaine, et le Sénat peut se le permettre, il est important de comprendre que les meilleures solutions dans ce domaine seront celles qui amèneront une action qui sera poursuivie à long terme. Même s'il y a des actes qui peuvent être posés ayant un impact immédiat, il faut éviter de boucher les trous et plutôt regarder l'ensemble de la situation.

[Traduction]

Le président: Merci beaucoup, monsieur Lalonde. J'ai bien saisi votre argument en faveur du financement global, c'est-à-dire du versement d'une somme forfaitaire à la place des coûts, car je suis d'accord avec vous concernant la rigidité. Le financement global me gênait beaucoup moins que les points fiscaux. Vous avez parlé du crédit politique. Il me semble qu'il est difficile pour un gouvernement de bénéficier du crédit politique lorsqu'il n'a pas eu à endurer la douleur politique de l'imposition. Céder des points fiscaux signifie en pratique que le contribuable individuel paie moins à un gouvernement et davantage à l'autre, mais il paie quand même le même montant. C'est à cela qu'est revenu le transfert de points fiscaux.

Mon opinion à l'époque que c'était cela qui entamait la légitimité du rôle du gouvernement fédéral, plus que le financement global. Cela m'amène à me demander si la Loi canadienne sur la santé ne devrait pas simplement être perçue comme une façon pour le gouvernement fédéral de regagner la légitimité qu'il a perdu en cédant les points fiscaux. Autrement dit, il s'est dit: «Notre seule légitimité réelle provient de la portion en espèces, autant adopter une loi pour convaincre les Canadiens que nous nous soucions du système de soins de santé». Je caricature délibérément pour mettre en lumière le problème, mais j'aimerais votre avis sur les points fiscaux et la légitimité de la Loi canadienne sur la santé une fois que vous avez cédé les points fiscaux.

M. Lalonde: Premièrement, le transfert de points fiscaux n'était pas une chose nouvelle en 1974. Nous l'avions déjà fait au Québec pour l'éducation postsecondaire bien avant 1974. En substance, c'était un arrangement politique avec les provinces. Nous avons acheté la paix à un certain prix, cela ne fait pas de doute.

L'enjeu était politiquement très important au Québec en particulier, mais les provinces en général se plaignaient de ce que le gouvernement fédéral dépense dans un domaine de compétence

matters or provincial jurisdictions. We argued that, indeed, we were using the constitutional spending power that we had. It was clear that these programs would be in operation, we assumed, for a long time. Some provinces had tax points that brought in more money than others, and the provincial governments were insisting that they would feel much more reassured that they were not at the whim of the federal government if at least part of the transfer was in the form of tax points. It certainly had the impact of reducing the visibility of the contribution of the federal government, but that was the background for it at the time.

As to the 1984 act, I do not think it had anything to do with reasserting our visibility. It had to do with a genuine concern that there was, through the back door, erosion of the basic elements of medicare generally. Extra billing and additional fees for hospital care were creeping in right and left, and there was a necessity for the federal government to reassert the basic principles that were enshrined in the first legislation and to try to set up regimes that would provide for greater accountability in the way the provinces were using federal funds, in particular, for the public in general and for the federal government.

If you must look for a rationale for the 1984 act, I do not think you should look for it in terms of trying to recuperate some lost visibility that the federal government did not have or had lost. It was essentially that there was federal legislation that provided for fundamental principles to which the federal Parliament was unanimously attached. We were seeing erosion that, if not stopped at that time, might have led to a dismantling of the whole national system as we knew it. That was the rationale behind it.

Senator LeBreton: Mr. Lalonde, on the question of the block funding and the tax points and the Established Programs Financing Act, you advised quite rightly to take the long view. In view of what has gone on in the intervening years and the misunderstanding of the general public on the whole tax points issue, would you do it all over again? There is such misunderstanding in the public. I think that is part of the reason the federal government seems to be not getting as much credit as perhaps it deserves in health care funding. If you had to do it all over again, in hindsight, would there have been a better way to explain it to the public? I actually think that if you were to go to Main Street Canada and ask about the tax point system, people would not have a clue what it means in the individual provinces and would not know that some provinces use it in different ways than others.

Mr. Lalonde: I bet you that even inside Parliament there are many parliamentarians who would be at a loss to know what tax points mean in their own provinces. That is a very important and difficult question. Is your question to the effect that if it were to be done again we should not go down the tax point road?

Senator LeBreton: Using the benefit of hindsight, do you think that, from the federal government's perspective particularly, there would have been a way to get out of the 50-50 formula and do block funding and tax points so that it would have been clear to the public exactly what that meant?

provinciale. Nous répliquions que nous nous servions simplement de notre pouvoir de dépense constitutionnel. Il était évident que ces programmes resteraient en place pendant longtemps. Certaines provinces avaient des points fiscaux qui leur rapportaient davantage qu'à d'autres, et les provinces disaient avec insistance qu'elles seraient beaucoup plus rassurées, moins à la merci du gouvernement fédéral, si au moins une partie du transfert prenait la forme de points fiscaux. Cela a certainement eu pour effet de réduire la visibilité de la contribution du gouvernement fédéral, mais voilà quel était le contexte à l'époque.

Pour ce qui est de la Loi de 1984, je ne pense pas qu'il se soit agi en rien de récupérer notre visibilité. Elle procédait de la crainte sincère d'une érosion des éléments fondamentaux de l'assurance-maladie, par des moyens détournés. Un peu partout nous voyons apparaître la surfacturation et des redevances supplémentaires pour les soins hospitaliers, et il était impératif que le gouvernement fédéral réaffirme les principes fondamentaux inscrits dans la première loi et mette en place des régimes obligeant les provinces à mieux rendre compte, au public en général et au gouvernement fédéral, de l'usage qu'elle fait des fonds fédéraux.

Si vous cherchez l'explication de la Loi de 1984, elle ne réside pas dans une volonté du gouvernement fédéral de récupérer un peu de la visibilité qu'il a perdue. Il fallait impérativement une loi fédérale pour réaffirmer les principes fondamentaux auxquels le Parlement fédéral était unanimement attaché. Il commençait à y avoir une érosion de ces principes qui, si on ne l'enrayait pas, aurait pu entraîner le démantèlement de tout le système national tel que nous le connaissions. Voilà la logique que nous avons suivie.

Le sénateur LeBreton: Monsieur Lalonde, sur la question du financement forfaitaire et des points fiscaux et de la Loi sur le financement des programmes établis, vous disiez qu'il faut les considérer dans une perspective à long terme. Étant donné ce qui s'est passé depuis sachant que le grand public ne comprend rien à toute la question des points fiscaux, referiez-vous la même chose aujourd'hui? Il y a une telle ignorance de la part du public. Je crois que c'est l'une des raisons pour lesquelles le gouvernement fédéral n'obtient pas tout le crédit qu'il mérite sur le plan du financement de la santé. Si vous deviez recommencer à zéro, avec l'avantage de la rétrospective, aurait-il été possible de mieux expliquer cela au public? Je pense que si vous demandiez à l'homme de la rue ce qu'est le système de points fiscaux, vous verriez que les gens n'en ont pas la moindre idée ni ne savent que certaines provinces utilisent le système différemment des autres.

M. Lalonde: Je vous parie que même au Parlement, beaucoup de parlementaires seraient incapables de dire ce que signifient les points fiscaux dans leur province. C'est un problème important et difficile. Dites-vous que si nous pouvions recommencer, nous ne devrions pas opter pour les points fiscaux?

Le sénateur LeBreton: Avec l'avantage de la rétrospective, pensez-vous que le gouvernement fédéral aurait pu abandonner la formule 50-50 en faveur du financement global et des points fiscaux d'une manière que le public aurait pu mieux comprendre?

Mr. Lalonde: I do not know whether it would have been possible to arrive at an agreement with the provinces. We had this with post-secondary education in Quebec at first, and then agreement was finally arrived at on the basis of the transfer of tax points. I do not know whether we would have been able to have the Established Programs Financing Act without some tax point transfer with the provinces. One might say that we could have said, "The hell with you, provinces. You will get it in cash and that is it." There would have been a row, but it would have been just another row in the history of Canada.

It was decided at the time that this was a reasonable compromise. If you assume that this was the right thing to have done at the time, I would say that the federal government should have been much more aggressive in spelling out what its contribution was year after year to the various provincial programs. I have always thought that the federal government was excessively discrete in that regard.

It was like the equalization payments that were going to Quebec and the Atlantic provinces and Manitoba in particular. I remember arguing with my officials and saying, "Well, why don't I go with a big cheque and deliver it with the media present? At least people will know something is happening." The response I got not only from the officials but also from colleagues in cabinet and from other provinces was, "No, if you do that, we will face a backlash in Ontario because they would say there goes another zillion dollars out of our pockets to Quebec or to the Maritimes and so on." We never did bite the bullet. We said, "So be it. We will need to explain to the people of Ontario and Alberta that it is good for Canada and that we should do it."

The shared cost program is not a lost cause by any means. The federal government should not hesitate to spend money on letting the public know where the money comes from and what it is for. I certainly would have no qualms as a taxpayer if the federal government were to spend money in that field. Canadian citizens have the right to know who is paying for what. However, to do that, you need a kind of systematic program of information as to what is done and how.

Senator LeBreton: Perhaps the ministers of health can do that when they meet. I think the public is confused. They look at the bottom-line dollar. It seems that now many things are hidden under the tax point issue. When they put all these issues on the table, the ministers of health can help the public sort out the confusion over what exactly each level of government does. That confusion is part of the problem. It is why people are starting to lack faith in the system. They really do not understand, and therefore they get their information from newspapers or from some horror story in a part of the country that might have no relation to the real situation. I wonder what the solution would be.

Mr. Lalonde: It is interesting. While I think most citizens recognize that health services are under provincial responsibility, it seems that a large part of the population believes that the federal

M. Lalonde: Je ne sais pas si nous serions parvenus à un accord avec les provinces. Nous avons utilisé une première fois ce système pour l'éducation postsecondaire au Québec, et l'accord avec les provinces a finalement été conclu sur la base du transfert de points fiscaux. Je ne sais pas si nous aurions pu adopter la Loi sur le financement des programmes établis sans un transfert de points fiscaux aux provinces. Nous aurions peut-être pu les envoyer au diable et leur dire de se contenter des versements en espèces. Il y aurait eu une bagarre, mais cela n'aurait jamais été qu'une de plus dans l'histoire du Canada.

Nous avons décidé à l'époque que c'était un compromis raisonnable. En admettant que c'était une bonne chose à faire à l'époque, je dirais que le gouvernement fédéral aurait dû expliquer de manière beaucoup plus agressive quelle était sa contribution aux divers programmes provinciaux, année après année. J'ai toujours trouvé que le gouvernement fédéral se montrait excessivement discret à cet égard.

C'était comme les paiements de péréquation versés au Québec et aux provinces de l'Atlantique, et au Manitoba en particulier. Je me souviens de discussions avec mes fonctionnaires où je disais: «Pourquoi ne vais-je pas là-bas avec un gros chèque pour le remettre en présence des médias? Au moins, les gens verront ce que nous faisons». La réponse, non seulement de mes fonctionnaires mais aussi de mes collègues et ministres et des autres provinces était: «Non, si vous faites cela, il y aura un tollé en Ontario parce que les gens diront qu'un autre zillion de dollars sort de leurs poches au profit du Québec ou des Maritimes et cetera». Nous n'avons jamais osé faire face et dire «Tant pis. Il faudra expliquer aux Ontariens et aux Albertains que c'est pour le Canada et c'est nécessaire».

Le programme de partage des coûts n'est pas une cause perdue, loin de là. Le gouvernement fédéral ne devrait pas hésiter à dépenser pour des campagnes visant à informer le public d'où vient l'argent et à quoi il sert. Pour ma part, je n'aurais aucune objection, comme contribuable, à ce que le gouvernement fédéral dépense de l'argent pour cela. Les citoyens canadiens ont le droit de savoir qui paie quoi. Mais pour cela, il faut un programme d'information systématique expliquant ce que l'on fait et pourquoi.

Le sénateur LeBreton: Peut-être les ministres de la Santé pourraient-ils faire cela lorsqu'ils se rencontrent. Le public n'y comprend rien, il ne voit que les chiffres. Les points fiscaux obscurcissent beaucoup de choses. Les ministres de la Santé, en mettant tous les problèmes sur la table, pourraient aider le public à s'y retrouver dans toute cette confusion sur ce que fait exactement chaque niveau de gouvernement. Cette confusion est un élément du problème. C'est pourquoi les Canadiens commencent à douter du système. Ils ne comprennent pas réellement, et n'ont comme information que ce qu'ils lisent dans les journaux ou quelques exemples désastreux dans une région du pays qui n'a pas de rapport avec la situation réelle. Je me demande quelle est la solution.

M. Lalonde: C'est intéressant. Je crois que la plupart des citoyens reconnaissent que les services de santé relèvent de la responsabilité provinciale, mais il semble qu'une grande partie de

government is not doing its share. I think there is a message for federal parliamentarians and federal government in that regard.

I also believe that contribution in tax points should not just be written off on the basis of, "It is gone, so it is gone." It is something that the federal government, at a certain stage, has said we will withdraw. That contribution, in my view, is still there. There is a way of evaluating it, certainly in terms of the contribution of the federal Parliament to provincial programs in the field of health or in the general field of the services covered now with the new system, which includes post-secondary education and health and welfare. At least there is a way of assessing the federal government's share. It is more difficult to be specific, because of the integration of the contributions, but the federal government could establish a fair distribution of those costs on the basis of the historical contributions and carry it forward. That could be done.

To come back to the last point in my presentation, I think the federal government has a very important role to play in terms of political leadership in the fields of health promotion and prevention in Canada and research. The research institutes that have been funded are a very important contribution of the federal government. Some of the research is funded 100 per cent, and much of the promotion and prevention could also be funded 100 per cent. It would be better if it could be done in full cooperation with all actors in the field. The federal government would get recognition for it. The legislation that you have passed in the tobacco sector is certainly related to health, and that is definitely federal leadership and a federal contribution that I believe the public has identified. They may not relate it to health directly, but it is. It is a matter of doing your political job of selling to the Canadian people the purpose of your actions in that field.

Senator Carstairs: Mr. Lalonde, was it ever envisaged under the Established Programs Financing Act that a point would be reached when the tax points would become almost the entire contribution of the federal government? That was the argument given, as you know, for the introduction of the Canada Health and Social Transfer. It appeared that Quebec would be the first province to no longer get any cash transfer but rather simply get tax points.

Mr. Lalonde: We never foresaw that Quebec would be in a position where the tax points would cover the full contribution of the federal government, and I do not believe it has happened yet. I do not know for sure, but I would be extremely surprised.

Senator Carstairs: However, that was, in fact, the rationale given for introducing the Canada Health and Social Transfer. The graph seemed to show that, as the tax points were getting larger, by the year 2002 Quebec would no longer get any cash transfer.

Mr. Lalonde: Perhaps, but I can tell you that that was not a particular concern at that time. We knew then that Alberta and Ontario might very quickly be in a situation where tax points would cover the federal contribution because of the more rapid

la population estime que le gouvernement fédéral ne fait pas sa part. Je trouve qu'il y a là un message pour les parlementaires fédéraux et le gouvernement fédéral.

Je pense également que la contribution sous forme de points fiscaux ne devrait pas simplement être passée par pertes et profits. Le gouvernement fédéral, à un moment donné, a cédé une part de son assiette fiscale. Cette contribution, à mon avis, existe toujours. Il y a moyen de l'évaluer, d'évaluer la contribution du Parlement fédéral aux programmes provinciaux dans les domaines de la santé et des autres services couverts par le nouveau système, c'est-à-dire l'éducation postsecondaire, la santé et l'assistance sociale. Il y a moyen d'évaluer la part du gouvernement fédéral. Il est plus difficile de donner des chiffres pour chaque volet, étant donné l'intégration des contributions, mais le gouvernement fédéral pourrait établir une ventilation équitable de ces coûts sur la base des contributions historiques et les projeter vers l'avant. C'est possible.

Pour revenir au dernier point de mon exposé, le gouvernement fédéral a un rôle très important à jouer dans le domaine de la promotion de la santé et de la prévention des maladies, ainsi que de la recherche. Les instituts de recherche qu'il finance représentent une contribution très importante du gouvernement fédéral. Certaines des recherches sont financées à 100 p. 100, et certaines activités de promotion et de prévention pourraient également être financées à 100 p. 100. Il vaudrait mieux que ce soit fait avec la pleine coopération de tous les acteurs dans ce domaine. Ainsi, le gouvernement fédéral verrait son action reconnue. La loi sur le tabac que vous avez adoptée est certainement liée à la santé, et c'est là un leadership et une contribution de niveau fédéral que le public perçoit. Il ne les relie peut-être pas directement à la santé, mais c'est néanmoins lié. Il s'agit pour vous de faire votre travail politique et d'expliquer aux Canadiens le but de vos actes dans ce domaine.

Le sénateur Carstairs: Monsieur Lalonde, avez-vous jamais songé au moment de la Loi sur le financement des programmes établis que l'on arriverait un jour à un stade où les points fiscaux représenteraient pratiquement toute la contribution du gouvernement fédéral? C'est l'argument qui a présidé, comme vous le savez, à l'introduction du transfert canadien en matière de santé et de sécurité sociale. Il est apparu que le Québec serait la première province à ne plus toucher du tout de transfert en espèces, seulement les points fiscaux.

M. Lalonde: Nous n'avions jamais prévu que le Québec serait dans une situation où les points fiscaux couvriraient toute la contribution du gouvernement fédéral, et je ne pense pas que ce soit déjà le cas. Je ne suis pas certain, mais j'en serais extrêmement surpris.

Le sénateur Carstairs: Mais c'était bien là l'explication donnée pour l'introduction du transfert canadien en matière de santé et de services sociaux. Le graphique semblait montrer que, au fur et à mesure que les points fiscaux augmentaient en valeur, le Québec ne recevrait plus de transfert en espèces en 2002.

M. Lalonde: Peut-être, mais je peux vous dire que ce n'était pas un sujet de préoccupation particulier à l'époque. Nous savions alors que l'Alberta et l'Ontario pourraient très rapidement être dans une situation où les points fiscaux couvriraient toute la

growth of the tax points in those provinces. We felt that the advantage of flexibility and the possibility for the provinces to be much freer in determining their health policy and their social policy had a higher importance than for us as federal politicians to walk around saying we pay 50 per cent. We thought that we could and should be able to explain to the Canadian people that we were still making a contribution, albeit by tax points. It is a political job that must be done.

The importance of eliminating the distortions and rigidity of the system was well worth going the route of tax points and grants. It was not essential that it be in tax points; it could have been in grants. However, as I said, it was fundamentally a political fight. We felt that we did not need to go to war over tax points.

The Chairman: I guess I now understand exactly where I have had difficulty with the situation. Whether it was Quebec was not the issue. The data showed that in the period between 2002 and 2008, most provinces would not receive cash but only tax points. I said to myself, "Well, if I were a province not receiving any cash and getting only the revenue of the tax points that I got back in 1977, why would I not simply opt out of medicare and take the position that the feds are clearly not making any contribution?" Clearly, as a province I would not take the tax points, because to do that would create a colossal political problem. It would necessitate different levels of income tax in some provinces. That is the logic that has led me to be troubled by the tax point issue.

By the way, I absolutely agree that in 1977 it never crossed anyone's mind when one looked at the forecasts. It did not look like the cash would run to zero. However, I am bothered now because with no cash and only tax points, the minute a province decides to opt out, our leverage is gone. Therefore, I agree with Senator Carstairs. We went to the CHST to preserve a cash portion so that, in a sense, there would be a visible element of federal contribution and federal leverage and no one would opt out. Would you like to comment on that?

Mr. Lalonde: No.

The Chairman: Even though you do not want to, I would love to hear your comment.

Mr. Lalonde: I have been out of this game for too long. I think your analysis is quite right. The moment a province can claim that it is not getting any financial contribution from the federal government, why should it feel bound by federal rules? However, with some imagination, you can find other ways of putting the screws where they need to be put. I do not want to go into details there.

Senator Carstairs: My second question has to do with your report, which I think is as valid today as it was in 1974. There are determinants of health, and there are ways in which we can contribute to the better health of Canadians. My experience in a provincial legislature and at the provincial level shows me that governments are very reluctant to put into effect and to spend money on programs for which they cannot show a cost-benefit

contribution fédérale, vu la croissance plus rapide de leur valeur dans ces provinces. Mais nous jugions que la flexibilité et la possibilité pour les provinces de façonner plus librement leurs politiques sanitaires et sociales l'emportaient sur la faculté des politiciens fédéraux de se vanter de payer 50 p. 100. Nous pensions que nous pourrions et devrions expliquer aux Canadiens que nous faisons toujours une contribution, même sous forme de points fiscaux. C'est un travail politique qu'il faut faire.

L'importance de l'élimination des distorsions et de la rigidité du système valait bien que l'on prenne le chemin des points fiscaux et subventions. Il n'était pas essentiel que ce soit sous forme de points fiscaux, toute la contribution aurait pu être sous forme de subvention. Mais, comme je l'ai dit, c'était fondamentalement une bagarre politique. Nous avons jugé qu'il n'était pas nécessaire de partir en guerre à propos de points fiscaux.

Le président: Je comprends maintenant exactement pourquoi j'étais opposé à cette méthode. Peu importe que ce soit ou non le Québec, mais les données montraient que dans la période entre 2002 et 2008, la plupart des provinces ne recevraient plus d'espèces, seulement des points fiscaux. Je me disais: «Si j'étais une province ne touchant plus d'espèces et seulement les recettes des points fiscaux qu'on m'a données en 1977, pourquoi ne sortirais-je pas simplement de l'assurance-maladie puisque le gouvernement fédéral ne verse plus de contribution?» On ne va certainement pas retirer les points fiscaux aux provinces, car cela engendrerait un problème politique colossal. Il faudrait introduire des niveaux d'impôt sur le revenu différents selon les provinces. Voilà la logique qui motivait ma réticence face aux points fiscaux.

D'ailleurs, je reconnais tout à fait qu'en 1977 personne n'a jamais songé à cette éventualité, en regardant les prévisions. Il ne semblait pas que les espèces descendraient jamais à zéro. Mais cela m'inquiète aujourd'hui, car sans espèces et uniquement des points fiscaux, si une province décide de se retirer, nous n'avons plus de levier. Je suis donc d'accord avec le sénateur Carstairs. Nous avons introduit le transfert canadien pour préserver une portion en espèce afin qu'il reste une contribution fédérale visible, et un moyen de pression fédéral pour empêcher les provinces de sortir du système. Aimerez-vous me donner votre avis là-dessus?

M. Lalonde: Non.

Le président: Même si vous ne le voulez pas, j'aimerais bien entendre votre avis.

M. Lalonde: Cela fait trop longtemps que j'ai quitté la partie. Je pense que votre analyse est juste. Dès l'instant où une province peut prétendre qu'elle ne reçoit plus de contribution financière du gouvernement fédéral, pourquoi se sentirait-elle liée par les règles fédérales? Toutefois, avec un peu d'imagination, on peut trouver d'autres façons de serrer la vis là où il faut. Je ne veux pas entrer dans les détails.

Le sénateur Carstairs: Ma deuxième question porte sur votre rapport, qui me paraît aussi valide aujourd'hui qu'en 1974. Il existe des déterminants de la santé, et des façons de favoriser une meilleure santé chez les Canadiens. Mon expérience au niveau provincial me montre que les gouvernements sont très réticents à dépenser pour des programmes qui ne sont pas sous-tendus par une analyse de coûts-bénéfices. Chaque fois qu'ils ont supprimé

analysis. Every time they removed a preventive initiative, it was because we could not prove that it did what we thought it might do. How do we turn that around? How do we make people understand that prevention programs in fact can have as much if not greater effect on Canadians' good health as some intensive medical interventions?

Mr. Lalonde: May I start with an anecdote? It is one that arose right after the publication of that document. One of our first decisions as federal-provincial ministers at a conference following the publication of this book was to adopt unanimously the view that all provincial governments should pass a law imposing the compulsory wearing of seat belts in cars. Everyone was unanimous around the table. We all walked out of there, "Rah, rah, rah," press conference, unanimity, et cetera. The ministers of health went back home, and most of them were well received, but I can tell you that there were a few provinces where the transport minister was waiting with a big baseball bat, saying, "What are you doing in my bailiwick? There is no way you will decide for me what will happen on the roads of this province. That is not the responsibility of the health minister." There was even a province where they managed to pass the law but did not proclaim it for three or four years because the premier was concerned about backlash from the citizens.

We had statistics from New Zealand, which had passed a law in this regard, and from another country showing that with the adoption of the seat belt law you would see a reduction of approximately 25 per cent in serious injuries in car accidents. That happened in Canada as well. Within a few years, you could see the statistics showing the evidence. In the end, Alberta, which had previously refused, adopted the law, and Nova Scotia suddenly decided they would give Royal Assent to a law that they had adopted. The difference was the proof that it was effective, along with much pressure from community groups and organizations like the Canadian Public Health Association and others, which demonstrated to their provincial governments that something must be done.

Therefore, I believe that the role of community action will be extremely important. It is like the issue of environment. You impose rules and spend money knowing that you will not see the results tomorrow. The results will be in the medium and long terms.

There has been, in this country and elsewhere in the Western world, enough action by pressure groups and voluntary organizations that politicians have been forced to listen. You have green parties sitting in various Parliaments in Europe and elsewhere. The movement has taken a political form. The politicians that took too long to act saw a political opposition organize itself. In our system, political parties have been wise enough to move fast in order to avoid the creation of such a political party.

We need the type of action wherein the Minister of Health can be a leader, but he cannot be the only actor. There must be action that will take place on the basis of a collective action by the government, because in almost every instance it involves action by a number of departments of the government. Money is not the problem. A program of public education on obesity, for instance,

une initiative de prévention, c'était parce que nous ne pouvions pas prouver qu'elle tenait ses promesses. Comment changer cela? Comme faire comprendre que les programmes de prévention peuvent avoir autant d'effet, voire plus grands, sur la santé des Canadiens que certaines interventions médicales lourdes?

M. Lalonde: Puis-je commencer avec une anecdote? C'était peu après la publication de ce rapport. L'une de nos premières décisions, lors d'une conférence fédérale-provinciale des ministres de la Santé, après la publication de cet ouvrage, a été d'adopter à l'unanimité l'idée que tous les gouvernements provinciaux devraient promulguer une loi imposant le port de la ceinture de sécurité dans les voitures. Nous étions unanimes autour de la table. Nous sommes sortis de là gonflés à bloc, conférence de presse, unanimité, et cetera. Les ministres de la Santé sont rentrés chez eux et la plupart ont été bien accueillis, mais je peux vous dire que dans quelques provinces, le ministre des Transports les attendait avec une batte de baseball disant: «Qu'est-ce que tu fais sur mon terrain? Ce n'est pas toi qui va décider ce qui se passe sur les routes de cette province. Ce n'est pas le rôle du ministre de la Santé». Il y a même eu une province où la loi a été adoptée, mais sans être promulguée pendant trois ou quatre ans parce que le premier ministre craignait la réaction de l'électorat.

Nous avons des statistiques provenant de la Nouvelle-Zélande, qui avait une loi en ce sens, et d'un autre pays montrant que le port obligatoire de la ceinture de sécurité engendrait une réduction d'environ 25 p. 100 des blessures graves dans les accidents de la route. La même chose s'est produite au Canada. Les statistiques l'ont prouvé au bout de cinq ans. Finalement, l'Alberta, qui avait d'abord refusé, a adopté la loi et la Nouvelle-Écosse a soudainement décidé de donner la sanction royale à une loi précédemment adoptée. Ce qui a emporté la décision a été la preuve de l'efficacité, ainsi que les fortes pressions exercées par des groupes communautaires et des organisations comme l'Association canadienne de la santé publique et d'autres qui ont démontré à leurs gouvernements provinciaux qu'il fallait agir.

Je pense donc que l'action communautaire sera extrêmement importante. C'est comme dans le domaine de l'environnement. Vous imposez des règles et effectuez des dépenses, sachant que vous ne verrez pas les résultats demain. Les résultats n'apparaîtront qu'à moyen et long terme.

Les groupes de pression et organisations bénévoles ont fait suffisamment de campagnes, chez nous et ailleurs dans le monde occidental, pour que les politiciens soient contraints d'écouter. Des partis verts siègent dans les Parlements de différents pays d'Europe et d'ailleurs. Le mouvement y a revêtu une forme politique. Les politiciens qui mettaient trop longtemps à agir ont vu s'organiser une opposition politique. Chez nous, les partis politiques ont eu la sagesse d'agir assez vite pour éviter la création d'un tel parti politique.

Nous avons besoin d'un type d'action dont le ministre de la Santé peut être le chef de file, mais il ne peut être le seul acteur. Ce doit être une action collective du gouvernement, car dans presque tous les cas plusieurs ministères sont mis en jeu. Le coût n'est pas un problème. Un programme d'éducation publique sur l'obésité, par exemple, a un coût insignifiant comparé au budget

is insignificant compared to what you spend on the health budget. What we need is a determination to go ahead with programs and do it consistently. The problem is that it becomes fashionable for a little while, some action is taken, then ministers change and officials change. The first thing you know, the programs disappears because you do not get elected on this in six months, money goes elsewhere, and that is the end of the program. What we need is a program that will be adopted and that will be consistently followed by governments.

For decades in Canada we have had the *Canada Food Guide*. That publication was recognized as one of the first and best nutrition guides in the world. When I was minister of health and welfare we were mailing out monthly family allowance and old age pension cheques. Today that is done electronically, therefore inserts cannot be mailed in addition to those cheques. We had a policy whereby every month such an insert would be mailed with every cheque. Those inserts dealt with various topics on keeping yourself in shape, as well as healthy lifestyle and nutrition. We were promoting the *Canada Food Guide*, and we were sending calendars once a year. That is perhaps old-fashioned and out-of-date now, but perhaps it is done today by e-mail. However, I feel disappointed that we are not pursuing similar actions more aggressively and systematically. You would see results more rapidly than you might expect.

We had the program called ParticipAction, for instance, which was aggressively promoted at a time when the majority of the money came from the private sector. Television stations were giving free time to promote physical exercise and to discourage smoking. We have seen the impact of that in terms of the number of people suffering from cardiovascular diseases. Several years after ParticipAction was introduced, we could see the improved statistics. In regard to smoking, we have seen the impact in terms of cancer of the lung amongst men. Unfortunately, women have decided to catch up with men in smoking; therefore, we see the figures for lung cancer increasing in women.

It is not a matter of saying that it is wasted money, that we do not see the results. You can show, on the basis of a number of programs that have been implemented, where we have made an impact. You can put dollar signs over that impact in terms of increased productivity and people who are alive today and still working and contributing through their taxes to help people who need health care. I believe it is a very saleable proposition to Canadians and to governments, except that you must have the right political leadership that will pursue programs systematically and consistently.

The Chairman: Since you quoted the obesity data from the United States, in *Maclean's* this week there is an article stating that 25 per cent of Canadian children between the ages of 4 and 9 are obese. It is not just American data that we are reading.

Senator Keon: First of all, I was delighted to listen to you, Mr. Lalonde. I am pleased to hear positive suggestions and not

de la santé. Ce qu'il faut, c'est la volonté de mettre en place des programmes et de les maintenir. Le problème est qu'une mesure est à la mode pendant un moment, puis les ministres et les fonctionnaires changent. Ensuite, un beau jour, le programme disparaît parce que ce n'est plus un enjeu électoral au bout de six mois, les crédits vont ailleurs et c'est la fin du programme. Il faut plutôt un programme durablement suivi par les pouvoirs publics.

Nous avons au Canada depuis plusieurs décennies le *Guide alimentaire canadien*. Cette publication est reconnue comme l'un des premiers et des meilleurs guides diététiques du monde. Lorsque j'étais ministre de la Santé et du Bien-être social nous envoyions chaque mois par la poste les chèques d'allocation familiale et de pension de la vieillesse. Aujourd'hui, cela se fait électroniquement et c'est pourquoi on ne peut plus ajouter des encarts dans les enveloppes. Nous avions une politique telle que chaque mois un encart était inséré avec tous les chèques. Ces brochures traitaient de divers sujets intéressant la condition physique, l'alimentation et les habitudes de vie saines. Nous faisons la promotion du *Guide alimentaire canadien* et envoyions des calendriers chaque année. C'est peut-être maintenant une méthode démodée, mais on pourrait peut-être utiliser le courrier électronique. Quoi qu'il en soit, je suis déçu que ce genre d'action n'est pas entreprise plus vigoureusement et systématiquement. On verrait des résultats beaucoup plus rapidement qu'on ne le pense.

Nous avons, par exemple, le programme appelé ParticipAction, qui a été agressivement promu à une époque où la majorité des fonds provenaient du secteur privé. Les stations de télévision accordaient du temps d'antenne gratuit pour promouvoir l'exercice physique et décourager les gens de fumer. Nous en avons vu les effets sur le nombre des gens atteints de maladie cardiovasculaire. Nous avons constaté une amélioration des statistiques plusieurs années après l'introduction de ParticipAction. En ce qui concerne le tabac, on a vu l'effet sur le nombre de cancers du poumon chez les hommes. Malheureusement, les femmes ont décidé de fumer autant que les hommes et les chiffres de cancers du poumon chez les femmes sont en hausse.

On ne peut donc pas dire que c'est de l'argent gaspillé, qu'on ne voit pas de résultat. Au contraire, on peut mesurer l'effet de divers programmes mis en oeuvre. On peut chiffrer ces résultats, en termes de productivité accrue et de Canadiens encore en vie et contribuant par leurs impôts aux soins des malades. Je pense que c'est une idée très vendable aux Canadiens et aux pouvoirs publics, pourvu qu'il y ait une direction politique acceptant d'appliquer les programmes systématiquement et durablement.

Le président: Puisque vous avez cité les chiffres d'obésité américains, dans la *Maclean's* cette semaine on dit que 25 p. 100 des enfants canadiens entre 4 et 9 ans sont obèses. Les Américains ne sont pas les seuls touchés.

Le sénateur Keon: Tout d'abord, j'ai été ravi de vous écouter, monsieur Lalonde. Je suis heureux d'entendre des suggestions

just a litany of everything that has been done. I agree with all of your suggestions.

Mr. Lalonde: I have more suggestions if you leave me five minutes at the end, Mr. Chairman.

The Chairman: We will do that.

Senator Keon: I should like to see us as a committee try to get our country out of the conundrum where we have this big sinkhole of funds that the provinces are saddled with; in other words, traditional medicare paying hospital and physician costs is destroying them financially. Some of the provinces will soon have 50 per cent of their budgets gobbled up in this.

We have come a long way with many things. We have some excellent programs, information and expertise in population health. The same applies to public health. We have had tremendous progress in health research in the last four or five years with the institutes and so forth. You spoke about health education, which is an area where we have failed. We have made some headway but there has been no consolidated thrust in health education. I believe we have failed in leadership in health for political reasons. I do not know who would dare step out there and try to be the leader. It would take a great deal of political maturity to do that without disturbing the provincial counterparts.

I am not sure that any of the formulas for funding that have been here since the 1950s have been ideal, but I do think that the federal leadership must increase. Many of the determinants of health care are national. Certainly the smaller provinces cannot deal with these things when it comes to environment and many of the other issues.

I should like to hear you speak to how you would see the situation unfold whereby the federal government could at least assume the leadership to beef up the non-medicare components of the system. I will repeat them: to get population health plugged into the public health of the country; the health care delivery system; health research, with feedback and outcomes; and, most of all, a serious program of health education that would not need to be that expensive but that would have continuity.

Mr. Lalonde: Thank you for your kind words.

Indeed, as we have both said, in the broader sense, the broader meaning of health and health policy, the federal government has a very large role to play, but I do not believe that it should attempt to play that role alone. If some provinces do not want to cooperate, I would say, "So be it."

Take the case of health education. Today, with the means of communication we have, there is nothing preventing the federal government from using the Internet and television and radio as much as it wants to do health education. However, I think it would be more effective if health education were to be integrated into the educational system and could show up in the classroom with the people who are in daily contact with the kids. I can see some provinces immediately up in arms, saying, "The federal government is intruding into education." If they want to do it and finance it, fine. Why would they not agree to do it on a concerted basis with other provincial governments and with the federal government?

positives et pas seulement une litanie d'événements passés. Je souscris à toutes vos suggestions.

M. Lalonde: J'en aurai d'autres si vous me laissez cinq minutes à la fin, monsieur le président.

Le président: Vous les aurez.

Le sénateur Keon: J'aimerais que ce comité cherche les moyens de sortir notre pays de l'impasse financière où se trouvent les provinces; autrement dit, l'assurance-maladie traditionnelle couvrant les frais hospitaliers et médicaux les détruit financièrement. Cela va bientôt avaler 50 p. 100 du budget de certaines provinces.

Nous avons fait beaucoup de chemin sur bien des plans. Nous avons quelques programmes excellents, de bonnes données et un savoir-faire en matière de santé de la population. La même chose vaut pour la santé publique. Nous avons fait des progrès énormes sur le plan de la recherche médicale au cours des quatre ou cinq dernières années, avec les instituts, et cetera. Vous avez parlé d'éducation sanitaire, et c'est un domaine où nous avons échoué. Il y a eu quelques progrès, mais pas d'action concertée en matière d'éducation sanitaire. Je crois que nous avons échoué pour des raisons politiques. Je ne sais pas qui osera se lever et prendre l'initiative. Il faudra beaucoup de maturité politique pour le faire sans s'attirer les foudres des homologues provinciaux.

Je ne suis pas sûr qu'aucune des formules de financement qui se sont succédé depuis 1950 étaient idéales, mais je pense que le gouvernement fédéral doit prendre davantage d'initiatives. Nombre des déterminants de la santé sont d'envergure nationale. Les petites provinces, en tout cas, ne peuvent pas régler des problèmes tels que l'environnement et beaucoup d'autres choses.

J'aimerais avoir votre avis sur ce que le gouvernement fédéral pourrait faire pour renforcer au moins les éléments du système autres que l'assurance-maladie. Je les énumère de nouveau: aligner la santé de la population sur la santé publique; le système de prestation des soins de santé, la recherche médicale, avec bouche de rétroaction et chiffrage des résultats; et, surtout, un programme sérieux d'éducation sanitaire ont continué, qui ne serait pas forcément très coûteux.

M. Lalonde: Merci de vos aimables paroles.

Effectivement, comme nous le disons tous deux, le gouvernement fédéral a un rôle très important à jouer à l'égard de la santé et de la politique sanitaire au sens large, mais il ne devrait pas essayer de faire cavalier seul. Si certaines provinces ne veulent pas collaborer, tant pis pour elles.

Prenez le cas de l'éducation sanitaires. Avec les moyens de communications d'aujourd'hui, rien n'empêche le gouvernement fédéral d'utiliser l'Internet et la télévision et la radio autant qu'il veut pour l'éducation sanitaire. Mais ce serait plus efficace si l'éducation sanitaire était intégrée dans les programmes d'enseignement et prise en charge par les enseignants, qui sont quotidiennement en contact avec les enfants. Je vois déjà certaines provinces prendre les armes et dire: «Le gouvernement fédéral empêche sur l'éducation». Si elles veulent le faire et le financer elles-mêmes, très bien. Pourquoi n'accepteraient-elles pas de faire ce travail en concertation avec les autres gouvernements provinciaux et le gouvernement fédéral?

Consider the issue of nutrition and young children. Can we help them be less dependent on junk food? Well, you can certainly do something federally, but much of that will need to come out of the classroom. Which provincial minister of health or minister of education would be against that? However, in our system, that it is not the responsibility of a teacher, so someone will need to be assigned that responsibility, and that means increasing the education budget for that particular purpose. I do not think it would cost zillions, and I think it would be a good investment by provincial governments, but that implies that the minister of health and the minister of education would need to work together. If necessary, the minister of health could take some of his money to help the minister of education if the provincial minister of finance agrees to contribute.

I say the federal government can do a great deal. It will be better if it could be done on a concerted basis. It does not need to mean that the federal government will start putting money in primary education.

In my view, the total contribution of the federal government to the field of health should increase. As part of that increase, much can be done in terms of negotiating concerted action by the federal government and the provincial government in the directions you have indicated. I think that can be done, but it would certainly require increased funding by the federal government.

By the way, this is one of my general conclusions. I do believe that there is room for additional money going into the health sector in the Canadian economy. We have been as high as 10.1 per cent of our GNP, I believe, and that includes private and public contributions. We have been down as low as 8.9 per cent. At the present time, we are around 9.1 per cent or something like that. I do not think we need to raise our contributions to 14 per cent like the Americans, or even to 12 per cent. However, taking into account the severe impacts that have been felt in our system because of the federal and provincial retrenchments during the 1990s, there should be an appreciable jump over the next few years to repair the damages that the system has suffered in the last few years, and then there should probably be a stabilization of the contributions. I would think that if we were targeting something like 10 per cent of our GNP going to the health sector over the next few years, then gradually coming down to between 9.5 per cent and 10 per cent, we would find that we had quite a lot of money to do what we need to do. I would say again that that would include a large component that would go into promotion and prevention.

Senator Robertson: Mr. Lalonde, it was a pleasure working with you when you were a federal minister of health. We had a comfortable relationship, and the tensions that we see now did not seem to exist then. I must say, perhaps because I am the senior citizen around the table, that historical perspectives can bring back many good memories and programs that one tends to forget about momentarily.

I would think that it might be wise for this committee to forget about tax points. I do not say that to be contentious, but since we are doing the historical resource thing, I think it should be on the table. When those tax points were transferred to the provinces, it

Prenez le cas de l'alimentation des jeunes enfants. Pouvons-nous les aider à manger mieux? On peut certes agir au niveau fédéral, mais une bonne partie de cette éducation doit être dispensée en salle de classe. Quel ministre provincial de la Santé ou de l'Éducation pourrait y être opposé? Cependant, dans notre système, cela n'est pas le rôle de l'enseignant, et il faudra donc attribuer cette responsabilité à quelqu'un, ce qui signifie accroître le budget de l'éducation spécifiquement pour cela. Je ne pense pas que cela coûtera des milliards, et ce serait un bon investissement de la part des gouvernements provinciaux, mais suppose que le ministre de la Santé et le ministre de l'Éducation collaborent. Si nécessaire, le ministre de la Santé pourrait prendre une partie de ses fonds pour aider le ministre de l'Éducation, avec l'accord du ministre des Finances provincial.

Je dirais que le gouvernement fédéral peut faire beaucoup. Il vaudrait mieux que ce soit fait de manière concertée. Cela ne signifie pas que le gouvernement fédéral va commencer à financer l'enseignement primaire.

À mon avis, la contribution totale du gouvernement fédéral à la santé devrait augmenter. Avec cette majoration, on pourrait négocier des mesures concertées avec les provinces dans le sens que j'ai dit. Je pense que c'est possible, mais cela exigera certainement des dépenses accrues de la part du gouvernement fédéral.

C'est d'ailleurs là l'une de mes conclusions générales. Je pense qu'il y a place dans l'économie canadienne à dépenser plus pour la santé. Nous lui avons déjà consacré jusqu'à 10,1 p. 100 du PIB, je crois, chiffre qui englobe les dépenses privées et publiques. Le pourcentage est descendu jusqu'à 8,9. Actuellement, nous sommes autour de 9,1 p. 100. Nous n'avons pas besoin d'y consacrer 14 p. 100 comme les Américains, ni même 12 p. 100. Mais, vu les effets désastreux sur notre système des coupures fédérales et provinciales au cours des années 90, il faudrait majorer sensiblement les dépenses au cours des prochaines années pour réparer les dégâts des dernières années, puis peut-être stabiliser les contributions. Si nous prenions pour cible 10 p. 100 du PIB consacré à la santé au cours des années qui viennent, pour ensuite graduellement stabiliser le chiffre entre 9,5 p. 100 et 10 p. 100, on constaterait que nous avons pas mal d'argent pour faire le nécessaire. Une bonne partie de la somme devrait être réservée à la promotion et à la prévention.

Le sénateur Robertson: Monsieur Lalonde, cela a été un plaisir de travailler avec vous lorsque vous étiez ministre fédéral de la Santé. Notre relation était confortable et les tensions qui se manifestent aujourd'hui ne semblaient pas exister alors. Je dois dire, peut-être parce que je suis l'aînée autour de cette table, que la rétrospective remet en mémoire beaucoup de bons souvenirs et programmes que l'on tend à oublier un peu.

Je pense qu'il serait sage pour ce comité d'oublier les points fiscaux. Je ne le dis pas pour polémiquer, mais puisque nous en sommes à faire l'historique des ressources, autant le dire. Lorsque ces points fiscaux ont été transférés aux provinces, c'était un

was rather a fictitious gift. Those tax points were taken away from the provinces in the 1950s and 1960s. When they reverted back to the provinces, it balanced the books, shall we say, in those days. You may remember some of that debate. Knowing how the provinces feel about these issues — and they have longer memories even than I do about this — I do not think they will give up on that issue with too much grace, shall we say, or enthusiasm. I do think it is important to remember that as we look ahead to our recommendations and how we think we should proceed.

I was interested in all of your remarks, Mr. Lalonde, good comments as usual, but I want to come back to the preventive programs. I agree with everything about the preventive programs. How to get them there is another matter, but perhaps it can be worked out. You were talking about the 50-50 cost sharing in the early days. We well understood that the federal government had to get out of that because the provinces, as wily as we were and are, shoved everything conceivable under the roof so you would not find out about it. You had no control over the cost escalation. It was very successful.

Most of us around this table feel that health care must move away from the hospital. The health care of the future will be delivered in the community, either in the workplace, the school or the home, and only those very ill people who have life-threatening circumstances or serious invasive processes should be accommodated under the roof, shall we say. We know there are savings, because pilot projects around Canada have proved the efficiency of those outreach programs.

We need to get the public and the governments to accept those programs in the home, in the workplace and in the school. To that end, I wonder if the provinces would not work just as energetically to push the care out of the hospital if we had 50-cent dollars on that type of care. Nothing speaks more clearly to the provinces than money, and it would save everyone cash. Hospital care is a tremendous expense. Even with the reduction in beds per population, in many areas you are looking at 40 per cent of the hospital beds being cluttered up by people who could be taken care of elsewhere. We need a carrot to get them out of there. You might be able to do it just with certain clearly defined programs, so that the games could not go on like they used to. Surely we are innovative enough to strengthen and save the program.

I do not need to remind you, Mr. Lalonde, that we are having a very rough time in our small provinces. Newfoundland is on a per capita basis, which I think is insane. Goodness knows where that came from, but it should not be that way. The smaller provinces with the smaller populations need a base to build on, and they do not have that base.

Would you like to comment on my ramblings?

Mr. Lalonde: Thank you, Senator Robertson, for your kind words and fond memories, which are reciprocal.

You talk about small provinces. It is not only the small provinces that have a serious problem. I was looking at the spending per capita in 1998 in Canada. The province that is spending the least per capita is not one of the small Atlantic

cadeau plutôt fictif. En effet, ils avaient été enlevés aux provinces dans les années 50 et 60. Lorsqu'ils ont été restitués, cela n'a fait que rétablir l'état des choses. Vous vous souviendrez de ce débat. Connaissant l'attitude des provinces dans ce domaine — et elles ont la mémoire plus longue encore que moi — je ne pense pas qu'elles céderaient là-dessus avec beaucoup de grâce, mettons, ou d'enthousiasme. Je pense qu'il importe de ne pas perdre cela de vue au moment de formuler nos recommandations et d'arrêter nos positions.

J'ai été intéressée par vos remarques, monsieur Lalonde, excellentes comme à l'accoutumée, et j'aimerais revenir sur les programmes de prévention. Je suis d'accord au sujet de ce que vous dites concernant les programmes préventifs. Comment les mettre en place, c'est une autre affaire, mais il y a peut-être moyen. Vous parliez du partage des coûts moitié-moitié au début. Il est bien évident que le gouvernement fédéral devait trouver une autre formule car les provinces, aussi astucieuses que nous l'étions et le sommes, ont fourré tout ce qu'elles ont pu dans cette enveloppe de manière subreptice. Vous n'aviez aucun contrôle sur l'augmentation du coût. Cela marchait très bien.

La plupart d'entre nous autour de cette table estimons que les soins doivent être moins axés sur l'hôpital. Les soins de l'avenir seront dispensés dans la collectivité, sur le lieu de travail, à l'école ou au domicile, et seules les personnes très malades, qui souffrent d'une maladie mettant en danger leur vie ou subissent de grosses opérations seront rassemblées, en quelque sorte, sous un même toit. Nous savons que cela offre des économies, car des projets pilotes un peu partout en ont apporté la preuve.

Nous devons amener le public et les gouvernements à accepter ces programmes à domicile, en milieu de travail et scolaire. Je me demande si les provinces ne s'engageraient pas dans cette direction avec plus d'énergie si elles ne payaient que la moitié de ce genre de soins. Les provinces ne comprennent rien de mieux que l'argent, et cela en fera économiser à tout le monde. Les soins hospitaliers sont une charge énorme. Même avec la réduction du nombre de lits per capita, dans bien des régions, 40 p. 100 des lits d'hôpital sont encombrés par des gens qui pourraient soignés ailleurs. Il faut une carotte pour qu'ils soient placés ailleurs. Il faudra peut-être pour cela mettre en place des programmes clairement définis, pour que le petit jeu du passé ne puisse plus être employé. Nous devons bien avoir assez d'imagination pour renforcer et sauver le système de santé.

Je n'ai pas besoin de vous rappeler, monsieur Lalonde, que nous avons beaucoup de difficultés dans nos petites provinces. Terre-Neuve a une formule per capita, ce qui est de la folie. Dieu sait d'où cela est venu, mais cela ne peut pas marcher. Les petites provinces, avec une faible population, ont besoin d'une fondation pour construire, et elles en sont démunies.

Pourriez-vous réagir à ces propos décousus?

M. Lalonde: Merci, sénateur Robertson, de vos aimables paroles et de vos bons souvenirs, que je partage.

Vous parlez des petites provinces. Il n'y a pas que les petites provinces qui ont un grave problème. J'ai vu les dépenses per capita au Canada en 1998. La province qui dépense le moins per capita n'est pas une des petites provinces de l'Atlantique, mais le

provinces but Quebec, by quite a margin. Those figures are not official figures, but they were reproduced in *Le Devoir* of Saturday, April 30.

No doubt there has been much pressure, but there is also no doubt in my mind that there needed to be some pressure on the system. For 14 years I have been chairman of a large hospital in Montreal. We have been able to cut considerably without reducing the service to the people. There was a great deal of inefficiency in the system, and there still remain rigidities, partly due to the fact that it is a heavily trade-unionized environment. In the first few years I was there, you could not move a nurse from one floor to the other because the labour agreement provided that she could work in that department and that was it. I could go on and on about that. There was a cozy arrangement that had existed for a long time, and it was very difficult to effect change. Only the threat of hanging concentrated the mind and made us do many of the changes that could and should have been done before.

You are suggesting fundamentally introducing new distortions in the system. I would be very reluctant to encourage you to move in that direction, unless it were to be on very specific programs. It should be clear that it will be only for a very short time — five years, whatever — in order to jump start a system that pretty well everyone agrees on. Otherwise, you will see what we had with hospitalization insurance. Many people who should not have been in the hospital were in those beds because the federal government was paying 50 per cent of the bill.

If you could identify specific programs so that you would not end up with distortion in the distribution of health care and not end up with bad cost allocation, fine. However, I would hope that the federal government would not commit itself long-term in that respect, because you will end up distorting the allocation of funds generally, and that is the difficulty with those programs. I would rather see the federal government say, "We will pay 50-50, or 30 per cent or 40 per cent, but it will be for the whole field having to do with health in a very broad way, including health promotion and health prevention."

If we must go that way, I do not think we should target it. These definitions have changed considerably over the years, and we are discovering new ways of doing things with the passage of time. If you introduce rigidity in the allocation of funds, there will be a cost to pay for that.

Senator Robertson: I would not anticipate rigidity. I would consider a very selective process, and certainly it would have to be as an introductory program to concentrate the mind that things can happen outside the hospitals. As you say, 30 per cent in the broad spectrum is interesting also. Provinces may enjoy that more. However, there are ways today of definition that perhaps we did not have 30 years ago. There are ways of yardsticking programs today that we did not have 30 years ago. Measurable results are more easily obtained than they used to be. They are not easy, they are difficult, but there are yardsticks. It would be challenging for us to look at some of these things.

Mr. Lalonde: My preference would always be that programs would be paid for 100 per cent by the federal government.

Québec, par un écart sensible. Ce ne sont pas des chiffres officiels, mais ils ont été reproduits dans *Le Devoir* du samedi 30 avril.

Il ne fait aucun doute qu'il y a eu beaucoup de pressions, mais aucun doute non plus dans mon esprit qu'il était nécessaire d'en exercer. J'ai présidé pendant 14 ans un grand hôpital de Montréal. Nous avons réussi à réduire considérablement les coûts sans réduire le service aux malades. Il y avait beaucoup de gaspillage dans le système, et il reste beaucoup de rigidité, notamment parce que c'est un milieu très fortement syndiqué. Pendant mes premières années, on ne pouvait déplacer une infirmière d'un étage à un autre parce que la convention collective stipulait qu'elle travaillait dans ce service et pas dans un autre. Il y avait un arrangement douillet pendant longtemps, et il était très difficile d'opérer des changements. Seule la menace de la pendeaison parvenait à concentrer les esprits et à autoriser les changements qui auraient pu et dû être faits.

Vous envisagez, en substance, d'introduire de nouvelles distorsions dans le système. Je serais très réticent à vous suivre dans ce sens, à moins qu'il s'agisse de programmes très spécifiques. Et pour une courte durée — cinq ans, mettons — pour mettre en place un système convenant à tout le monde. Sinon, on retrouvera la même chose qu'avec l'assurance-hospitalisation. Beaucoup de gens qui ne devraient pas être à l'hôpital occupaient ces lits, parce que le gouvernement fédéral payait 50 p. 100 de la facture.

Si vous pouviez identifier des programmes spécifiques qui n'entraînent pas une distorsion de la prestation des soins de santé et une mauvaise répartition des coûts, très bien. Toutefois, j'espère que le gouvernement fédéral ne s'engagerait pas à long terme car on fausserait la répartition générale des fonds, et c'est bien là l'écueil de ces programmes. J'aimerais mieux que le gouvernement fédéral dise: «Nous allons payer 50-50, ou 30 p. 100 ou 40 p. 100, mais ce sera pour l'ensemble du domaine de la santé, englobant la promotion de la santé et la prévention.»

S'il faut payer plus, je ne pense pas qu'il faille cibler la contribution. Toutes ces définitions ont beaucoup évolué au fil des ans, et nous découvrons de nouvelles façons de faire les choses avec le passage du temps. Si vous introduisez une rigidité dans la répartition des fonds, il faudra en payer le prix.

Le sénateur Robertson: Je n'envisage pas de rigidité. Je songe à un processus très sélectif, afin de montrer que certaines choses peuvent être faites en dehors des hôpitaux. Vous dites, une quote-part de 30 p. 100 des dépenses totales est également une possibilité. Les provinces pourraient préférer cela. Toutefois, il y a des moyens de définir les programmes qui n'existaient pas il y a 30 ans. Il y a des moyens de tailler les programmes sur mesure qui n'existaient pas il y a 30 ans. On peut plus facilement mesurer les résultats que jadis. Ce n'est pas très simple, mais il y a des étalons. Il serait intéressant de se pencher sur certaines de ces choses.

M. Lalonde: Ma préférence sera toujours que les programmes soient payés à 100 p. 100 par le gouvernement fédéral.

Senator Callbeck: I, too, certainly appreciate your attending. I enjoyed working with you. Your remarks brought back memories about things I had not thought about for quite a while, such as the orange paper and the white paper and what was an eligible expense for the 50-cent dollars and so on. I had forgotten how rigid the system was then.

I wish to ask you about the Canada Health Act. We have heard experts say that it is outdated and that it is not flexible enough to allow for innovative reforms. We have also heard experts give the opposite opinion. I should like to hear your views on that. On the five criteria — comprehensiveness, public administration, universality, portability and accessibility — do you feel that any of those should be abolished and others added?

Mr. Lalonde: Many people blame the Canada Health Act for something it was not trying to do. The act does not introduce rigidity. The five criteria existed before. The Canada Health Act introduces clearer definitions through regulations, or otherwise, to ensure that these rules mean something. In that sense perhaps there is some rigidity. I have no qualms whatsoever about saying that the federal Parliament should maintain the five criteria that were enacted by Parliament in the past. In my view, those criteria remain as valid as they ever were.

I have not seen anywhere in the world anyone with the magic wand and the perfect solution. Our system is not perfect, but overall I see its problems as being manageable sometimes with money, but sometimes also with appropriate leadership and a sense of initiative. Those criteria, in my view, should not be abandoned or modified, certainly not in the current conditions. I see no problems in the present regime that would require abandoning those five criteria in order to correct or remedy those problems. Therefore, my position on this is clear and categorical.

The financing provides for a tremendous amount of flexibility. The provinces can do whatever they wish with the money they are getting now under the new financing regimes. With that, there are specific requirements to be respected for medical care and hospital care, quite clearly. I believe those requirements should be maintained. Nothing prevents a province from spending more money on home care or more money on health professionals other than doctors, if they wish to do so. They can use the federal funds for that purpose, but it is clear that for medical and hospital care you have some basic criteria. If some physicians prefer to opt out of the system, let them opt out. They are free to opt out but they cannot walk both sides of the street at the same time. That is the rule and I believe it is a good rule.

Senator Cook: I come from the smallest province, Newfoundland and Labrador.

Mr. Lalonde: I thought the smallest province was Prince Edward Island.

Senator Cook: In population, I believe Newfoundland is the smallest province.

Mr. Lalonde: I did not have the impression that Newfoundland had shrunk in the last few years.

Senator Cook: We are scattered more than in Prince Edward Island. We are further away from the tertiary care hospitals, of which there are only two at the moment. I have served on a

Le sénateur Callbeck: Moi aussi j'apprécie que vous soyez venu. J'ai aimé travailler avec vous. Vous m'avez remis en mémoire des choses auxquelles je n'avais pas pensé depuis quelque temps, telles que le Livre orange et le Livre blanc et ce qu'était une dépense admissible pour le partage 50-50, et cetera. J'avais oublié à quel point le système était rigide alors.

J'aimerais parler de la Loi canadienne sur la santé. Des experts nous ont dit qu'elle est désuète, pas assez flexible pour autoriser des réformes novatrices. D'autres experts ont émis l'avis contraire. J'aimerais connaître votre point de vue. Sur les cinq critères — couverture complète, administration publique, universalité, transférabilité et accessibilité — pensez-vous qu'il faille en abolir ou en ajouter d'autres?

M. Lalonde: Beaucoup de gens reprochent la Loi canadienne sur la santé des choses qu'elle n'était pas censée faire. La loi n'introduit pas de rigidité. Les cinq critères existaient auparavant. La Loi canadienne sur la santé introduit des définitions plus claires, par le biais du règlement ou d'autres façons, pour donner un contenu à ces règles. En ce sens, il y a peut-être un peu de rigidité. Mais je n'hésite pas à dire que le Parlement fédéral doit conserver les cinq critères qu'il a adoptés par le passé. À mon avis, ils restent aussi valides que jamais.

Je n'ai pas vu non plus ailleurs dans le monde de baguette magique et de solution parfaite. Notre système n'est pas parfait, mais dans l'ensemble les problèmes peuvent être réglés, tantôt avec de l'argent, tantôt un esprit d'initiative. À mon avis, ces critères ne doivent pas être abandonnés ou modifiés, certainement pas dans la situation actuelle. Je ne vois aucun problème dans le régime actuel qui exigerait l'abandon des cinq critères de façon à remédier à ces problèmes. Par conséquent, ma position à ce sujet est claire et catégorique.

Le financement permet énormément de flexibilité. Les provinces peuvent faire tout ce qu'elles veulent avec l'argent qu'elles touchent. En sus, il y a des exigences spécifiques à respecter sur le plan des soins médicaux et hospitaliers, clairement énoncés. Je pense qu'il faut les conserver. Rien n'empêche une province de dépenser plus pour les soins à domicile ou pour le personnel paramédical, si elles le souhaitent. Elles peuvent utiliser les fonds fédéraux pour cela, mais il est clair que pour les soins médicaux et hospitaliers il faut des critères de base. Si certains médecins veulent se retirer du système, qu'ils le fassent. Ils sont libres, mais ils ne peuvent pas avoir les deux en même temps. C'est la règle, et je la trouve bonne.

Le sénateur Cook: Je viens de la plus petite province, Terre-Neuve et Labrador.

M. Lalonde: Je pensais que la plus petite province était l'Île-du-Prince-Édouard.

Le sénateur Cook: Je pense qu'en chiffre de population, Terre-Neuve est la plus petite.

M. Lalonde: Je ne pensais pas que Terre-Neuve avait rétréci ces dernières années.

Le sénateur Cook: Notre population est plus dispersée que celle de l'Île-du-Prince-Édouard. Nous sommes plus loin des hôpitaux de soins tertiaires, dont il n'existe actuellement que

hospital board for the past nine years and have struggled through the pangs of managing hospitals and turning seven into one and so on, and it was not easy. Out of that I saw some positive things emerge, one being community health and the other being home care. In our struggle to amalgamate and to be efficient, we have moved from one position to the other.

Having listened to all the other questions and answers, my question is this: When and how are we going to move outside of the lines from illness to wellness?

Mr. Lalonde: The federal financing at the present time encourages this. There is no restriction any more as to where the provinces allocate their funds in the field of health. They must respect some standards on the two programs I indicated, but otherwise they can allocate funds as they wish. For that, it is in the hands of provincial governments, who under our Constitution have the responsibility for those services. That is the way our country has worked and will continue to work, I suspect, for a long time. The federal government, again, can provide leadership, encouragement, political and financial support, but health services will be done essentially by provincial authorities and with much community involvement and community support.

That is the way Canadians are doing things and that is the way it should be done under a democratic system. I do not see the federal government taking the place of the provinces in that regard. You have seen those changes yourself in Newfoundland, and changes for the good. There has been significant improvement in terms of federal-provincial cooperation in the field of health. The Canadian Institute for Health Information, for instance, is a welcome development. I understand that there are now federal-provincial committees at a high level that are working quite cooperatively, as far as I can see, because all governments find themselves with their backs to the wall now. There may be a fair amount of posturing at times by political leaders, but at the official level people realize they must carry on working, and they should be encouraged in that direction. I will come back to what I have said in terms of concentration on the broadest interpretation of health and health policy, and I believe we can make progress.

I could conclude quite rapidly, Mr. Chairman, because I have bootlegged what I had intended to say into my responses to some of the last questions. I should like to repeat, however, that the five basic criteria that are in operation at the present time should be maintained. I do not believe that our system is broken, that we must rebuild it all over again starting from scratch more or less. I hear declarations by political leaders that the status quo is not an option. That depends on what they mean. If they mean that we must scrap what we have, I feel they are wrong. If they mean that we can improve on what we have, I feel they are right. I believe that many of those improvements can be brought in within the framework of what we have at the present time. We do not need to reinvent a whole new set of legislation in this field at the present time.

deux. J'ai siégé à un conseil d'administration d'hôpital au cours des neuf dernières années et ai souffert les affres des coupures, et ce n'était pas facile. Mais j'ai vu émerger certaines choses positives, l'une étant les soins communautaires et l'autre les soins à domicile. Dans notre effort de regrouper les services et de dégager des économies, nous sommes passés d'une position à une autre.

Ayant écouté toutes les autres questions et réponses, je me pose cette question: Quand et comment allons-nous sortir du cadre de la maladie pour entrer dans celui de la bonne santé?

M. Lalonde: Le financement fédéral actuel encourage cela. Il n'y a plus de restrictions à l'usage que peuvent faire les provinces de leurs fonds dans le domaine de la santé. Elles doivent respecter certaines normes dans les deux programmes que j'ai indiqués, mais sinon elles sont libres d'utiliser les fonds comme elles le veulent. Selon notre Constitution, les provinces ont la responsabilité de ces services. C'est ainsi que notre pays fonctionne depuis toujours et continuera de fonctionner pendant longtemps, ai-je l'impression. Encore une fois, le gouvernement fédéral peut encadrer, encourager, soutenir politiquement et financièrement, mais les services de santé doivent être assurés essentiellement pour les autorités provinciales, avec la participation et le soutien des collectivités.

Voilà la façon dont les Canadiens font les choses et la façon dont elles doivent être faites dans un système démocratique. Je n' imagine pas le gouvernement fédéral se substituer aux provinces à cet égard. Vous avez vu ces changements vous-mêmes à Terre-Neuve, qui vont dans le bon sens. Il y a eu des améliorations considérables au niveau de la coopération fédérale-provinciale dans le domaine de la santé. L'Institut canadien d'information sanitaire, par exemple, est une nouveauté utile. Je crois savoir qu'il y a maintenant des comités fédéraux-provinciaux de haut niveau travaillant en concertation, d'après ce que je peux voir, car tous les gouvernements se retrouvent dos au mur aujourd'hui. Parfois les politiciens fanfaronnent, mais au niveau des fonctionnaires, on se rend compte qu'il faut collaborer et nous devons les encourager en ce sens. Je répète ce que j'ai dit au sujet de la concentration sur l'interprétation la plus large possible de la santé et de la politique sanitaire, et je pense que nous pouvons progresser.

Je vais conclure rapidement, monsieur le président, car j'ai déjà intégré une partie de ce que je voulais dire dans mes réponses aux dernières questions. Mais je répète que les cinq critères fondamentaux actuels doivent être maintenus. Je ne pense pas que notre système soit cassé, qu'il faille le reconstruire entièrement à partir de zéro. J'entends dire ici et là des dirigeants politiques dire que le statu quo n'est pas une option. Tout dépend de ce qu'ils entendent par là. S'ils veulent dire que nous devons mettre au rebut ce qui existe, ils ont tort. S'ils veulent dire qu'on peut améliorer ce qui existe, ils ont raison. Je pense que beaucoup de ces améliorations peuvent être introduites dans le cadre actuel. Nous n'avons pas besoin de réinventer tout un nouvel ensemble de lois à ce stade.

The honourable senators should ask themselves a couple of very simple questions to put it into perspective. Do we have, in Canada, a medical profession of high quality? I think Canadians in general would say yes.

Do we have health professionals who are competent and devoted to their profession? I would say in general yes, although there have been many morale problems with the troops because they have been hit right and left with difficult constraints in the last decade.

Do our institutions offer services that are comparable to the services offered in other developed countries? Definitely. The question is whether you are right at the top or right at the bottom. The answer is that we may not be at the top, but we are surely not at the bottom.

Is the life expectancy for Canadians comparable to that of other OECD countries? Only Britain and Japan have a longer life expectancy amongst the OECD countries, and it is interesting that they spend less on health services than we do in proportion to their GNP.

Is our infant mortality rate lower than that of other countries? Yes, our infant mortality is amongst the lowest in the world.

Is your regulation of health products, drugs and food providing Canadians with safe drugs and food? One must say yes, comparatively. Again, nothing is ever perfect, but look around.

Do we allocate a share of our GNP or per capita to health comparable to other countries? Again, it compares favourably. It is lower than the United States, especially per capita, but again our statistics indicate that, with the lower allocation of funds, we have been able to achieve pretty good result in terms of our national health.

I do not mean that there are no serious problems. Otherwise, you would not have been at work here, and your committee would not have been set up. However, I think we must put this in perspective and determine our task as a society, as Canadians.

I have already said that, in my view, there should be an increase in the share of public funding going to health, but that is not only a federal matter. In my own province of Quebec, for instance, the public expenditure going to health has gone down more significantly than the federal contribution has gone down. Both federal and provincial governments must look at their books in that regard and realize that, on a per capita basis at least, most provinces have cut to a point where now is the time to reintroduce significant funding.

My last point would be that I hope we can arrive at a regime between the federal and provincial governments where there will be stability in funding. We know why governments had to cut, but, in terms of health policy, this is no way to run a peanut shop. You need a regime where you know over the next several years how you will be operating.

In my province, I have seen radical and arbitrary cost cutting, and decisions have been taken that were purely looking at the short term. The Minister of Finance wanted to have a smaller

Les sénateurs devraient se poser à eux-mêmes quelques questions très simples pour mettre les choses en perspective. Avons-nous, au Canada, une profession médicale de haute qualité? Je pense que les Canadiens en général répondraient oui.

Avons-nous des professionnels de la santé compétent et dévoués à leur profession? En règle générale oui, bien qu'il y ait quelques problèmes de moral au sein des troupes qui ont été assaillies à gauche et à droite de contraintes difficiles au cours des dix dernières années.

Est-ce que nos institutions offrent des services comparables à ceux que l'on trouve dans les autres pays développés? Absolument. La question est de savoir si nous sommes proche du sommet ou proche du fond. La réponse est que nous ne sommes peut-être pas au sommet, mais nous ne sommes certainement pas au bas de l'échelle.

L'espérance de vie des Canadiens est-elle comparable à celle des autres pays de l'OCDE? Seuls la Grande-Bretagne et le Japon ont une espérance de vie plus longue et il est intéressant de noter qu'ils consacrent moins à la santé en proportion de leur PIB.

Notre mortalité infantile est-elle inférieure à celle des autres pays? Oui, elle est parmi les plus basses du monde.

Est-ce que notre réglementation des produits sanitaires, médicaments et aliments assure aux Canadiens une nourriture et des médicaments sûrs? Il faut répondre oui, comparativement. Encore une fois, nul n'est parfait, regardez autour de vous.

Allouons-nous à la santé une part de notre PIB ou une dépense per capita comparable à celle des autres pays? Encore une fois, la comparaison nous est favorable. Nos dépenses sont inférieures à celles des États-Unis, surtout per capita, mais les chiffres montrent qu'en dépit de cela nous obtenons d'assez bons résultats sur le plan de la santé nationale.

Je ne cache pas qu'il y a des problèmes sérieux. Sinon, vous ne seriez pas là à faire ce travail et votre comité n'aurait pas été créé. Cependant, je pense qu'il faut remettre les choses en perspective et voir quelle est notre tâche en tant que société, que Canadiens.

J'ai déjà dit qu'à mon avis il faudrait augmenter la part des dépenses publiques consacrées à la santé, mais ce n'est pas seulement une affaire fédérale. Dans ma province du Québec, par exemple, la part des dépenses publiques allant à la santé a considérablement baissé depuis que la contribution fédérale a diminué. Les gouvernements, tant fédéral que provinciaux, doivent examiner leurs comptes et réaliser que, du moins sur une base per capita, la plupart des provinces ont coupé à un point tel qu'il faut maintenant réinvestir.

Enfin, j'espère que nous pouvons arriver à un régime tel que le financement, fédéral et provincial, soit stable. Nous savons qu'il a fallu faire des coupures, mais dans le domaine de la santé, on ne peut pas gérer à la petite semaine. Il faut un régime où l'on sait plusieurs années d'avance comment les choses vont fonctionner.

J'ai vu dans ma province des coupures radicales et arbitraires et des décisions qui ne tenaient compte que du court terme. Le ministre des Finances voulait avoir un déficit réduit l'année

deficit next year, and that was it. We ended up with the early retirement of nurses in Quebec. We made them an offer that they could not refuse. Next thing we knew, we were short of nurses. We are rehiring those willing to come back and paying them hefty remuneration. We are in a situation now where we are even sending people to the United States to be treated at public expense. Surely, this could have been foreseen. Surely, we know what the needs of the population will be over the next few years. It is mind boggling to see situations like this, and it is totally unacceptable. I can understand why there is such an outcry amongst the people in Canada about the current situation and the tendency to say, "A plague on both your governments' houses. It is your job to fix it; get going."

I hope that there will arise out of your deliberations a recommendation that the federal government at least look at providing a stable base of financing over the next decade.

The Chairman: Thank you for attending, Mr. Lalonde. We all appreciate not only your ideas but also your candour. Above all else, it is wonderful for us to see that your passion for public policy does not seem to have abated much in the 16 years you have been gone.

The committee adjourned.

suivante, et on coupait. On a mis les infirmières au Québec à la retraite anticipée. Nous leur avons fait une offre qu'elles ne pouvaient refuser. Maintenant, nous sommes à court d'infirmières. Nous réembauchons celles qui veulent revenir et leur payons des primes conséquentes pour cela. Nous sommes même obligés d'envoyer des gens se faire soigner aux États-Unis, aux frais de l'État. Tout cela était prévisible. Nous savons aujourd'hui quels seront les besoins de la population au cours des prochaines années. Il est incroyable de voir des situations comme celle-ci, et c'est totalement inacceptable. Je comprends pourquoi les Canadiens sont autant indignés et portés à dire: «Que le diable emporte vos deux gouvernements, c'est votre travail de réparer les dégâts, faites-le».

J'espère que vous recommanderez au gouvernement fédéral, à l'issue de vos délibérations, d'assurer au moins un financement de base stable pour les dix prochaines années.

Le président: Merci d'être venu, monsieur Lalonde. Nous apprécions tous non seulement vos idées, mais aussi votre franchise. Par-dessus tout, il est merveilleux de voir que votre passion pour la politique publique ne semble pas s'être atténuée depuis 16 ans.

La séance est levée.



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WITNESS—TÉMOIN

As an individual:

The Honourable Marc Lalonde, P.C.

À titre personnel:

L'honorable Marc Lalonde, c.p.



Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

*Proceedings of the Standing
Senate Committee on*

*Délibérations du comité
sénatorial permanent des*

Social Affairs, Science and Technology

Affaires sociales, des sciences et de la technologie

Chairman:
The Honourable MICHAEL KIRBY

Président:
L'honorable MICHAEL KIRBY

Wednesday, May 31, 2000

Le mercredi 31 mai 2000

Issue No. 16

Fascicule n° 16

Eleventh meeting on:
The state of the health care system in Canada.

Onzième réunion concernant:
L'état du système de santé au Canada

WITNESS:
(See back cover)

TÉMOIN:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Beaudoin	Gill
* Boudreau, P.C. (or Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Pépin
Cook	Robertson
Corbin	

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Pépin substituted for that of the Honourable Senator Banks (*May 29, 2000*).

The name of the Honourable Senator Banks substituted for that of the Honourable Senator Pépin (*May 29, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Beaudoin	Gill
* Boudreau, c.p. (ou Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Pépin
Cook	Robertson
Corbin	

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Pépin substitué à celui de l'honorable sénateur Banks (*le 29 mai 2000*).

Le nom de l'honorable sénateur Banks substitué à celui de l'honorable sénateur Pépin (*le 29 mai 2000*).

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, May 31, 2000

(23)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 3:30 p.m., the Chair, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Callbeck, Carstairs, Cohen, Cook, Gill, Keon, Kirby, LeBreton and Robertson (9).

Other senators present: The Honourable Senators Banks, Fairbairn, P.C., Roche and Wilson (4).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore.

Also in attendance: The official reporters of the Senate.

Pursuant to the Order of Reference adopted by the Senate on Thursday, November 25, 1999, the committee continued its consideration of the developments since the tabling in June 1995 of the final report of the Special Senate Committee on Euthanasia and Assisted Suicide, entitled "Of Life and Death". (*For complete text of Order of Reference see Proceedings of the Committee, Issue No. 2.*)

The Chair made a statement.

Senator Carstairs moved — That the Chair and Deputy Chair be authorized to receive and adopt, on behalf of the Standing Senate Committee on Social Affairs, Science and Technology, the report of the Subcommittee to Update "Of Life and Death" on the developments since the tabling in June 1995 of the final report of the Special Senate Committee on Euthanasia and Assisted Suicide, entitled: "Of Life and Death"; and

— That Senator Carstairs be authorized to table in the Senate the said report on behalf of the Chairman of the Standing Senate Committee on Social Affairs, Science and Technology.

The question being put on the motion, it was adopted.

WITNESS:

As an individual:

The Honourable Monique Bégin, P.C.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see Proceedings of the Committee, Issue No. 8.*)

The Chairman made a statement.

PROCÈS-VERBAL

OTTAWA, le mercredi 31 mai 2000

(23)

[Traduction]

Le comité sénatorial permanent des affaires sociales des sciences et de la technologie se réunit aujourd'hui, à 15 h 30, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Callbeck, Carstairs, Cohen, Cook, Gill, Keon, Kirby, LeBreton et Robertson (9).

Autres sénateurs présents: Les honorables sénateurs Banks, Fairbairn, c.p., Roche et Wilson (4).

Également présente: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 25 novembre 1999, le comité poursuit son étude des faits nouveaux survenus depuis le dépôt, en juin 1995, du rapport final du comité sénatorial spécial sur l'euthanasie et l'aide au suicide intitulé: «De la vie et de la mort». (*Pour le texte intégral de l'ordre de renvoi, voir les Délibérations du comité, fascicule n° 2.*)

Le président fait une déclaration.

Le sénateur Carstairs propose — Que le président et la vice-présidente soient autorisés à recevoir et à adopter, au nom du comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le rapport du sous-comité de mise à jour de «De la vie et de la mort» sur les faits nouveaux survenus depuis le dépôt, en juin 1995, du rapport final du comité sénatorial spécial sur l'euthanasie et l'aide au suicide intitulé «De la vie et de la mort»; et

— Que le sénateur Carstairs soit autorisée à déposer au Sénat ledit rapport au nom du président du comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

La question, mise aux voix, est adoptée.

TÉMOIN:

À titre personnel:

L'honorable Monique Bégin, c.p.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale de l'état du système de santé au Canada. (*Pour le texte intégral de l'ordre de renvoi, voir les Délibérations du comité, fascicule n° 8.*)

Le président fait une déclaration.

Ms Bégin made a statement and answered questions.

At 4:45 p.m., the committee adjourned to the call of the Chair.

ATTEST:

Mme Bégin fait une déclaration et répond aux questions.

À 16 h 45, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

EVIDENCE

OTTAWA, Wednesday, May 31, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 3:30 p.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Before resuming our hearings on our study on the state of the health care system in Canada and what needs to be done to it or for it, depending on your point of view, we have one motion that we need to put through the committee. I wish to remind you that a subcommittee has been doing an update on the report of the Special Senate Committee on Euthanasia and Assisted Suicide from five years ago, which was entitled "Of Life and Death." That report has been done by a subcommittee chaired by Senator Carstairs. That subcommittee has completed its report and we need a formal motion to authorize the tabling of that report in the Senate next week, the fifth anniversary of the tabling of the original report. I do not think the motion requires much discussion, but it does require that it be moved formally and seconded and voted on.

Senator Carstairs: I move:

That the Chair and the Deputy Chair be authorized to receive and adopt, on behalf of the Standing Senate Committee on Social Affairs, Science and Technology, the report of the subcommittee to Update "Of Life and Death" on the developments since the tabling in June 1995 of the final report of the Special Senate Committee on Euthanasia and Assisted Suicide, entitled: "Of Life and Death;"

And that Senator Carstairs be authorized to table in the Senate the said report on behalf of the Chairman of the Standing Senate Committee on Social Affairs, Science and Technology.

Senator Fairbairn: I second the motion.

The Chairman: Is it agreed, honourable senators?

Hon. Senators: Agreed.

The Chairman: Carried.

Senator Roche: I wish to point out to the committee that Senator Carstairs did an outstanding job in steering this very difficult and delicate subject through a lengthy series of hearings. The committee produced an outstanding report, about which it should be very proud.

Hon. Senators: Hear, hear!

The Chairman: Congratulations, Senator Carstairs. The report is adopted.

We now continue our three-year study on the health system in Canada and the federal role therein. I am absolutely delighted to have as our witness today the Honourable Monique Bégin, who was health minister from 1977 to 1984, except for a nine-month interregnum in 1979. She was the author of the Canada Health Act in 1974. She subsequently went on to be Dean of Health

TÉMOIGNAGES

OTTAWA, le mercredi 31 mai 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 15 h 30, pour examiner l'état du système de santé au Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Avant de reprendre les audiences relatives à l'étude sur l'état du système de santé au Canada et les mesures à prendre à ce sujet, selon votre point de vue, notre comité est saisi d'une motion. Je souhaite vous rappeler qu'un sous-comité a procédé à la mise à jour du rapport du comité sénatorial spécial sur l'euthanasie et l'aide au suicide d'il y a cinq ans, qui est intitulé «De la vie et de la mort.» Ce rapport a été fait par un sous-comité présidé par le sénateur Carstairs. Le sous-comité a terminé son rapport et il nous faut une motion officielle pour autoriser le dépôt de ce rapport au Sénat la semaine prochaine, à la date marquant le cinquième anniversaire du dépôt du rapport initial. Je ne crois pas que la motion exige beaucoup de discussion, mais elle doit être proposée officiellement, appuyée et adoptée.

Le sénateur Carstairs: Je propose:

Que le président et la vice-présidente soient autorisés à recevoir et à adopter, au nom du comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le rapport du Sous-comité de mise à jour de «De la vie et de la mort» sur les faits nouveaux survenus depuis le dépôt, en juin 1995, du rapport final du comité sénatorial spécial sur l'euthanasie et l'aide au suicide intitulé «De la vie et de la mort»;

Et que le sénateur Carstairs soit autorisée à déposer au Sénat ledit rapport au nom du président du comité sénatorial permanent des affaires sociales des sciences et de la technologie.

Le sénateur Fairbairn: J'appuie la motion.

Le président: Est-ce d'accord, honorables sénateurs?

Des voix: D'accord.

Le président: La motion est adoptée.

Le sénateur Roche: J'aimerais souligner devant le comité que le sénateur Carstairs a fait un travail remarquable en tant que présidente d'une longue série d'audiences relatives à ce sujet très difficile et délicat. Le comité a produit un rapport remarquable dont il devrait être très fier.

Des voix: Bravo!

Le président: Félicitations, sénateur. Le rapport est adopté.

Nous poursuivons maintenant notre étude de trois ans sur le système de santé au Canada et le rôle fédéral à cet égard. Je suis ravi de recevoir aujourd'hui comme témoin l'honorable Monique Bégin, qui a été ministre de la Santé de 1977 à 1984, à l'exception d'une interruption de neuf mois en 1979. Elle est l'auteur de la Loi canadienne sur la santé de 1974. Elle a été ensuite doyenne

Sciences at the University of Ottawa, and she is now dean emeritus. When politicians get to the point where people are giving them that title, that is an enormous accolade, given the sort of titles typically attached to politicians after they retire.

We are delighted to have Ms Bégin here. As you all know, from time to time, she has not been shy about expressing her views and is well known to have some fairly strong views on what needs to be done to the Canadian health care system. We are delighted to be the recipient of those views today.

As we must adjourn at 4:45, in light of a vote being held in the Senate at 5:00 p.m. and a recorded vote at 5:30 p.m., I have indicated to Madam Bégin that we will want to have her back. We originally hoped to have a full two-hour session. Clearly, however, we will not have time for that today. We will ask her to give her opening presentation, followed by as many questions as we can ask within the time available to us. Please do not feel that this is your last opportunity to question her, because she has agreed that we will find another opportunity for her to return in the next few weeks or so, certainly before the end of June when we recess.

Thank you very much for being here. Please proceed with your opening statement.

The Hon. Monique Bégin, P.C.: First, I wish to address what has been stated in the press recently. I do not feel obliged to apologize because I do not think I did anything wrong. Nevertheless, I wish to give you an explanation. I am not appearing in front of you this afternoon after having told the media what I would say here today. That is not the case. In fact, May and April are very busy months for me. I attend annual meetings and give key note addresses, and so on, where I have either spoken or written about medicare. I continue to do so, as if it is an evolution.

I wish I had a plan like the one that has been attributed to me, because if I knew how to fix medicare I would be prime minister, or at least the premier of a province. Most of what is written in the newspapers — and I was upset when I read the press this morning — comes from an article in the last issue of “Policy Options,” which is entirely on medicare and several people have written about it.

[Translation]

I succeeded Marc Lalonde part way through September of 1977 and I read with great interest his deposition as well as the answers he gave to your questions several days ago. I inherited EPF after it had been up and running for two and a half months.

Prior to that, I served as Minister of National Revenue for one year. I suppose I voted in favour of EPF both in Cabinet and in the House of Commons. The vast majority of my Cabinet and caucus colleagues confided in me several years later, while we were in the throes of this so-called health crisis, that they were not quite sure what they were voting for. We were dealing with an extremely complex administrative system and this was the first time, to my knowledge, that a decision was made to replace a

des Sciences de la santé à l'Université d'Ottawa et aujourd'hui, y est professeur émérite. Lorsque les politiciens en arrivent au point où on leur confère ce titre, c'est une très grande marque d'approbation, compte tenu du genre de titres qu'on leur confère habituellement au moment de leur retraite.

Nous sommes ravis de recevoir Mme Bégin aujourd'hui. Comme vous le savez tous, elle peut être très directe de temps à autre, lorsqu'elle exprime ses points de vue et elle est bien connue pour avoir des idées assez arrêtées sur les mesures à prendre au sujet du régime de soins de santé canadien. Nous sommes ravis de pouvoir entendre ses points de vue aujourd'hui.

Comme nous devons lever la séance à 16 h 45 en raison d'un vote qui doit avoir lieu au Sénat à 17 heures et d'un vote par appel nominal à 17 h 30, j'ai indiqué à Mme Bégin que nous devons de nouveau l'inviter. Nous avions à l'origine espérer avoir une séance de deux heures. De toute évidence, ce n'est pas possible aujourd'hui. Nous allons lui demander de faire sa déclaration préliminaire, puis nous poserons le plus de questions possibles dans le temps qui nous est disponible. Ne pensez pas que c'est la dernière fois que vous pouvez lui poser des questions, car elle a accepté de revenir au cours des prochaines semaines, certainement avant la fin juin, avant les vacances.

Merci beaucoup d'être parmi nous. Je vous cède la parole.

L'honorable Monique Bégin, c.p.: J'aimerais tout d'abord revenir sur ce qui a été récemment dit dans les médias. Je ne me sens pas tenue de m'excuser, car je ne pense pas avoir fait quelque chose de mal. Toutefois, je tiens à vous donner une explication. Je ne comparais pas devant vous aujourd'hui après avoir dit aux médias ce que je me propose de vous dire ici. Ce n'est pas le cas. En fait, mai et avril sont des mois très chargés pour moi. Je fais des discours-programmes dans le cadre d'assemblées annuelles ou j'ai déjà parlé du régime d'assurance-maladie, ou écrit à ce sujet. Je continue de le faire comme si la situation évoluait.

Je voudrais bien avoir un plan comme celui qui m'a été attribué, car, si je savais comment remettre le système à niveau, je serais premier ministre, ou à tout le moins, premier ministre d'une province. La plupart de ce qui est écrit dans les journaux — j'ai d'ailleurs été dérangée par ce que j'y ai lu — est extrait d'un article du dernier numéro de «Options politiques» qui porte entièrement sur le régime d'assurance-maladie; plusieurs personnes ont écrit à ce sujet.

[Français]

J'ai succédé à Marc Lalonde à la mi-septembre 1977, et lu avec grand intérêt sa déposition ainsi que ses réponses à vos questions il y a quelques jours. J'ai hérité de EPF alors qu'il existait depuis deux mois et demi.

Auparavant, j'avais été ministre du ministère du Revenu national, pour une période d'un an. Je suppose que j'avais voté pour EPF aussi bien au Conseil des ministres qu'à la Chambre des communes. La grande majorité de mes collègues au Cabinet et au caucus m'ont confié, plusieurs années après, quand nous étions dans ce que l'on a appelé la «crise de l'assurance-santé», ils ne savaient pas ce sur quoi ils votaient. Je veux dire que c'est un système administratif excessivement complexe et c'était le

cost-shared program with lump-sum payments. When the "crisis" was brought to my attention during Question Period in the House of Commons in January 1979, and I documented these events in my book on public policy, I had been Minister of Health for two and a half years and I had not really been apprised of all of the aspects of the health care program.

[English]

Medicare was in very good health. Such were the times.

We were working on all sorts of health issues but not what we call, in lay language, medicare, meaning the health insurance system. The system was in good health and I had not been briefed on it. We had lots of work.

Mr. Lalonde's memory does not serve him as well as usual, because it was not 33 per cent but 25 per cent of the federal budget that represented the huge portfolio of National Health and Welfare at the time. I had the pleasure of dealing with some of you who were provincial ministers back then, working on the frontline, where I did not have to live every day.

I was on another frontline, though. Suddenly, I had to get involved, and for a very long time, in that particular dossier of public policy. I date it from January 1979 to September 1984, when there was a change of government and I left politics.

The government ended up tabling and obtaining unanimous passage of the Canada Health Act, to fix a problem, which derives, in my opinion, from EPF. Let me explain.

EPF, which Mr. Lalonde addressed when he came, was for the first time a lump-sum transfer payment, mainly in tax points and partly in cash.

As Professor Raisa Deber told you at the very beginning of your deliberations, the two main pieces of legislation that created medicare were the Hospital Insurance and Diagnostic Services Act and, ten years later, the Medical Care Act. Both acts continued to be in existence after EPF. It is the Canada Health Act of 1984 that did away with those two acts, by consolidating them into the Canada Health Act.

That is very interesting, and it is, of course, with hindsight that I, myself, understand the whole dossier more fully each day.

HIDSA and the Medical Care Act remain as the framing legislation for the existence and the justification of medicare funding from a federal viewpoint, but they had been completely castrated — I hope that is a good English term — of their powers of enforcement. Those pieces of legislation were conceived on a 50-50 sharing idea. Their enforcement was immediately, automatically, linked to that mode of funding. If there were not as many beds in hospital X or if the lab was not the right size or in the right location, the province was simply not reimbursed for the invoice.

premier cas, à ma connaissance, de paiements forfaitaires remplaçant un programme à frais partagés. Quand la «crise» a été portée à ma connaissance, lors de la période des questions, à la Chambre des communes, en janvier 1979 — et j'ai documenté le tout dans mon livre sur le dossier de la politique publique — j'étais ministre de la Santé depuis deux ans et demi, et je n'avais à peu près jamais été renseignée sur le programme de soins de santé.

[Traduction]

Le régime d'assurance-maladie était en très bonne santé. C'était le bon temps.

Nous travaillions sur toutes sortes de questions, mais par sur ce que nous appelons le régime de soins de santé lui-même. Le régime était en bonne santé et je ne recevais pas de briefing à ce sujet, nous avions beaucoup de travail à faire.

M. Lalonde n'a pas bonne mémoire cette fois-ci, car ce n'était pas 33 p. 100, mais 25 p. 100 du budget fédéral qui était affecté à l'énorme portefeuille du ministère de la Santé nationale et du bien-être de l'époque. J'ai eu le plaisir de travailler avec certains d'entre vous qui étiez ministres provinciaux à l'époque, et qui travailliez en première ligne, où je n'avais pas à constamment intervenir.

Je menais un autre combat, toutefois. J'ai dû m'occuper pendant très longtemps de ce dossier de politique gouvernementale. Je l'ai fait entre janvier 1979 et septembre 1984, date à laquelle j'ai quitté la politique par suite d'un changement de gouvernement.

Le gouvernement a fini par déposer et adopter à l'unanimité la Loi canadienne sur la santé, pour régler un problème qui découle, à mon avis, du FPE. Permettez-moi d'expliquer.

Le FPE, dont M. Lalonde a parlé, représentait pour la première fois un paiement de transfert forfaitaire, sous forme de points d'impôt essentiellement, et d'argent partiellement.

Comme Mme Raisa Deber vous l'a dit tout au début de vos délibérations, la Loi sur l'assurance-hospitalisation et les services diagnostiques et, dix ans plus tard, la Loi sur les soins médicaux, sont les deux principales mesures législatives à l'origine du régime d'assurance-maladie. Ces deux lois ont été maintenues après le FPE. C'est la Loi canadienne sur la santé de 1984 qui les a fait disparaître en les fusionnant.

C'est très intéressant et c'est, bien sûr, avec le recul, que je comprends mieux ce dossier chaque jour.

La Loi sur l'assurance-hospitalisation et les services diagnostiques et la Loi sur les soins médicaux restent la législation cadre qui justifie l'existence du financement du régime d'assurance-maladie d'un point de vue fédéral; elles ont toutefois été complètement dépouillées de leurs pouvoirs d'application. Ces mesures législatives étaient basées sur la notion de partage égal. Leur application a été immédiatement, automatiquement, liée à ce mode de financement. S'il n'y avait pas autant de lits dans l'hôpital X ou si le laboratoire Y n'était pas de la bonne taille ou ne se trouvait pas au bon endroit, la province n'était tout simplement pas remboursée.

The mode of enforcement was automatic. I insisted on that. To me, that is very important in legislative operations. In my personal opinion, that mode was the least punitive, if punitive at all. It was more a deprivation of funding at the other end. Province X could, though, go back and make adjustments. I did not use that method directly; it was changed during my time at Health and Welfare. A different invoice could be submitted once things were fixed and the province could be finally reimbursed 50 cents on the dollar.

The legislation continued in terms of what expenses were covered and how, but the funding mechanism, which by way of consequence was the enforcement mechanism, was totally divorced because it was EPF that did it. There was absolutely no mechanism of enforcement.

I must say that I never saw the regulations attached to these two old pieces of legislation. It may be interesting — and I will come back to that — to study those acts from the viewpoint of today's problems. In the years of the so-called crisis, my officials explained to me, for example, the five principles or conditions of the Canada Health Act that existed in the previous pieces of legislation. No one talked of them. The provinces knew them, but the public had never heard much about them. There were originally four principles. Accessibility was included as a sort of subtext of universality, but we extracted it and made it a formal fifth condition.

The legislation consolidated and did away with the two previous acts, borrowing everything it could from the spirit and the conditions of the previous acts. The new act did not fix something of which I was acutely aware, namely, that the previous legislation covered only what we knew to be "health care" at the time, meaning a doctor-based, hospital-based, acute-care system. Nothing else was paid for at that time.

I totally subscribe, no need to say, to everything that Mr. Lalonde said about health promotion and prevention. He made a presentation on producing and restoring health and preventing the erosion of health, other than through hospitals and doctors. I knew that should be done, but the times were such that it was not possible. It was the end of a political regime. Those were extremely difficult years in terms of the new economic ideologies. It seemed that everyone in Canada was against universality.

We have forgotten now, but there were several fights to begin cutting. The numerous cuts that took place in the second half of the 1980s and into the 1990s were written in the Department of Finance long before that. I am among those who fought those plans. We won a few; we lost a few as well.

My judgment, in terms of strategy, was that if we were to re-open the content of the old legislation everything could have been lost, from the federal view. I could have lost money. I could have lost important funds that were transferred to the provinces.

Le mode d'application était automatique. J'ai insisté sur ce point. À mon avis, c'est très important dans les opérations législatives. De mon point de vue personnel, ce mode d'application était le moins punitif, si tant est qu'il ait été. Il s'agissait plus d'une dépossession de financement à l'autre extrémité. La province X pouvait toutefois faire des ajustements. Je n'ai pas utilisé cette méthode directement; elle a été modifiée lorsque j'étais à Santé et Bien-être. Une facture différente pouvait être présentée une fois la situation réglée et la province pouvait finalement être remboursée pour la moitié de ses frais.

La législation a continué de s'appliquer du point de vue des dépenses visées, mais le mécanisme de financement, qui par voie de conséquence a été le mécanisme d'application, en a été complètement dissocié, à cause du FPE. Il n'y avait absolument pas de mécanisme d'application.

Je dois dire que je n'ai jamais vu les règlements liés à ces deux anciennes lois. Il serait intéressant — et je vais revenir là dessus — d'examiner ces lois sous l'angle des problèmes d'aujourd'hui. Pendant les années de la soi-disant crise, mes fonctionnaires m'ont expliqué, par exemple, les cinq principes ou conditions de la Loi canadienne sur la santé qui existaient dans les mesures législatives précédentes. Personne n'en parlait. Les provinces les connaissaient, mais le public n'en avait jamais beaucoup entendu parler. Il y avait à l'origine quatre principes. L'accessibilité était incluse comme découlant en quelque sorte de l'universalité, mais nous en avons fait une cinquième condition officielle.

La loi a fusionné les deux lois précédentes, reprenant tout ce qu'elle pouvait de l'esprit et des conditions des lois précédentes. La nouvelle loi n'a pas réglé un problème dont j'avais parfaitement conscience, à savoir que la législation précédente ne visait que ce que nous définissions comme «soins de santé» à l'époque, c'est-à-dire un système lié aux médecins, aux hôpitaux, aux soins actifs. Rien d'autre n'était remboursé à ce moment-là.

Je suis complètement d'accord — il est inutile de le dire — avec tout ce qu'a dit M. Lalonde au sujet de la promotion de la santé et de la prévention dans ce domaine. Il a dit qu'il serait bon de maintenir et de rétablir la santé et de prévenir l'érosion de la santé par des moyens autres que ceux offerts par les hôpitaux et les médecins. Je savais qu'il fallait le faire, mais l'époque était telle que cela n'a pas été possible. C'était la fin d'un régime politique. Ces années ont été extrêmement difficiles vu les nouvelles idéologies économiques. Il semblait que tout le monde au Canada était contre l'universalité.

Nous l'avons oublié maintenant, mais plusieurs batailles ont été menées à propos des compressions. Les nombreuses compressions qui ont été faites dans la deuxième moitié des années 80 et dans les années 90 avaient été prévues bien avant par le ministère des Finances. Je fais partie de ceux qui se sont battus contre ces plans. Nous avons remporté quelques victoires, mais nous avons perdu également quelques batailles.

En matière de stratégie, je pensais que si l'on rouvrait le contenu de l'ancienne législation, tout aurait pu être perdu, du point de vue fédéral. J'aurais pu perdre de l'argent. J'aurais pu perdre les fonds importants qui étaient transférés aux provinces.

The government to which I belonged may have used the occasion for capping in a major way or for cutting, or whatever. That was my political judgment, which, of course, I could not say at the time.

Some of the provinces could not immediately start other programs. They would have seen my efforts to modernize the list of costs that were covered by federal money as being unfair to the provinces. To elaborate, I would have been imposing on the provinces additional health care costs but without increasing the transfer money. There were a few political problems; let us put it that way.

Thus, I stick with the strict medical hospital type of definition. Nurses have played an historic role, even though the premiers changed the name from medical practitioner to health professional, or something like that. Although it was a great political victory, in practice it did not change anything in the delivery of the health care system.

The Canada Health Act was meant to address the only visible problem of the day, that is, extra charges, through two avenues. There was extra-billing by some physicians, in particular specialists, and user fees were levied by some institutions under provincial authority in some of the provinces.

It took a long time to clarify how far we could go and still respect the Constitution and the division of power, in that health care delivery is a provincial responsibility. I wanted the officials from Justice to help me with what I had heard were new ideas in legislation, mainly to have enforcement mechanisms that were not punitive. Hence, the provinces had three years in which they could put their houses in order. They would have the penalty applied, if it applied, but if their house was put in order before the end of the three years they would get the money back. Then, of course, there was the dollar-for-dollar concept, a concept that is not only fair but which appeared to be fair to the public. I have always thought that the participation of citizens has always been important. It is the citizenry who has always saved medicare whenever there were problems.

I once asked my predecessor in the portfolio why these three main actors — Mr. Trudeau, Mr. Don Macdonald, who was then minister of finance, and Mr. Lalonde, all from the legal tradition — had not put in place an enforcement mechanism. I do not know if he remembers that, but he told me that both the feds and the provinces were so pleased with the EPF that everyone would act in good faith and that there would never be any problems. I do not judge the legal profession on that.

I inherited a problem that we just did not know what to do with. We conceived of a fair, simple, and quasi-automatic way of applying the act when it came to extra charges. At the time, it was not possible to foresee what forms other eventual encroachments or breaches would take. Thus, a second general section of the act deals with the general process of assessment, first, and then

Le gouvernement dont je faisais partie aurait pu profiter de l'occasion pour imposer des plafonds ou des compressions, et cetera. C'était mon jugement politique que, bien sûr, à l'époque, je ne pouvais pas formuler.

Certaines provinces ne pouvaient pas immédiatement lancer d'autres programmes. Elles auraient qualifié d'injustes mes efforts de modernisation de la liste des coûts couverts par le fédéral. Pour préciser les choses, j'aurais imposé aux provinces des coûts supplémentaires en matière de soins de santé sans augmenter les fonds de transfert. Disons que nous avons eu quelques problèmes politiques.

Par conséquent, je m'en tiens à la stricte définition des services médicaux et hospitaliers. Les infirmières ont joué un rôle historique, même si les premiers ministres ont changé leur titre, les appelant infirmières praticiennes ou professionnelles de la santé, et cetera. Même si c'était une grande victoire politique, en pratique, rien n'a changé dans la prestation des services de soins de santé.

La Loi canadienne sur la santé visait à régler le seul problème visible de l'époque, c'est-à-dire les frais supplémentaires, et cela de deux façons. Certains médecins faisaient de la surfacturation, les spécialistes en particulier, et certains établissements imposaient le ticket modérateur sous l'autorité provinciale dans certaines des provinces.

Il a fallu beaucoup de temps pour expliquer exactement jusqu'où il était possible d'aller, tout en respectant la Constitution et le partage des pouvoirs, vu que la prestation des services de santé est une responsabilité provinciale. Je voulais que les fonctionnaires de la Justice m'aident au sujet des nouvelles idées dans le domaine législatif — dont j'avais entendu parler —, surtout pour trouver des mécanismes d'application qui ne soient pas punitifs. Ainsi, les provinces disposaient de trois années pour mettre de l'ordre dans leurs affaires. Elles auraient été pénalisées, le cas échéant, mais si elles mettaient de l'ordre dans leurs affaires avant la fin des trois années, elles étaient remboursées. Puis, bien sûr, il y a eu le concept de partage égal, concept qui est non seulement juste, mais qui le semblait aux yeux du public. J'ai toujours pensé que la participation des citoyens est importante. Ce sont eux qui immanquablement ont sauvé le régime d'assurance-maladie chaque fois qu'il y a eu des problèmes.

J'ai un jour demandé à mon prédécesseur au portefeuille pourquoi ces trois principaux acteurs — M. Trudeau, M. Don Macdonald, qui était alors ministre des Finances, et M. Lalonde, tous issus du monde juridique — n'avaient pas prévu de mécanisme d'exécution. Je ne sais pas s'il s'en rappelle, mais il m'a répondu que tant le gouvernement fédéral que les provinces étaient si satisfaits du PFE que tout le monde agirait de bonne foi et qu'il n'y aurait jamais de problème. Je ne juge pas la profession juridique là-dessus.

J'ai hérité d'un problème dont nous ne savions tout simplement pas quoi faire. Nous avons conçu un moyen juste, simple et quasi-automatique d'appliquer la loi lorsqu'il y a des frais supplémentaires. À l'époque, il n'était pas possible de prévoir quelle forme prendraient d'autres éventuels empiètements ou transgressions de la loi. Donc une deuxième section générale de la

eventual penalties in the case of other breaches. I refer not to theoretical breaches but those that were unknown at the time.

That brings us to today's situation, where we see the face of possible threats to the system.

I wish I had a plan. I do not. Like everyone who is a specialist in the health care system, I know that some reforms and changes are absolutely essential. They have not taken place. They are slow in coming. Only the downsizing and restructuring of institutions has taken place. Even within that restructuring there has been a clash of institutional cultures, between hospitals that were forced to become one institution.

The Canada Health Act has taken on a life of its own. It has now reached the status of an icon. Because of that, I personally think that no politician can reopen the Canada Health Act, even to improve it, because it will destabilize people too much. Therefore, I came to the conclusion that, first, more money is needed. Second, that money should be cash, and certainly not tax points. Third, this should be done under a new piece of legislation which parallels the Canada Health Act. In theory, the Canada Health Act is about doctors and hospitals. However, in practice, the provinces do what they want with that money. Everyone plays on both levels all the time. In the process, citizens have lost their sense of entitlement, something that I find unacceptable in terms of public accountability.

The new act would cover home care and primary care, which should be the centre of the system but which is the periphery for the time being. I suggest that we would like to add one or two conditions. The first is accountability.

The Canada Health Act was passed sometime in April 1984. It became law on July 1, 1984. I left the portfolio, having known for a long time that I would be leaving it, although no one else knew. I ensured that the regulations pertaining to the enforcement of the penalties would be developed and approved. It was a long process. However, I then left the scene. I never saw any other regulations. I understand that some clauses of the regulations were not even drafted, which brings me to one particular section of the act that I find problematic. I refer to the section that deals with non-profit public administration, which is one of the five conditions.

Mr. Chairman, I will now end my remarks and answer any questions that you may have.

The Chairman: Thank you, Madam Bégin. Before turning to senators for questions, I would like to ask two by way of background. I will resist the temptation at this point to press you on some of your more provocative comments.

loi traite du processus général d'évaluation, tout d'abord, puis d'éventuelles pénalités dans le cas d'autres violations. Je ne parle pas de violations théoriques, mais de celles qui n'étaient pas encore connues à l'époque.

Ceci nous amène à la situation qui prévaut aujourd'hui, où l'on entrevoit des menaces possibles au système.

J'aurais voulu avoir un plan, mais je n'en ai aucun. Comme tout le monde qui connaît à fond le système de soins de santé, je sais qu'il est absolument impératif d'y faire certaines réformes et certains changements. Rien n'a été fait. Ils se font désirer. Il y a seulement eu réduction des effectifs et restructuration des institutions. Cette restructuration a d'ailleurs causé un choc des cultures institutionnelles, entre les hôpitaux qui ont été forcés de se fusionner.

La Loi canadienne sur la santé s'est animée d'une vie qui lui est propre. Elle jouit maintenant du prestige d'une icône. C'est pourquoi je pense personnellement qu'aucun politicien ne peut rouvrir la Loi canadienne sur la santé, ni même l'améliorer, parce que cela déstabiliserait trop la population. Par conséquent, j'en suis venue à la conclusion que, d'abord, il faut plus d'argent. Deuxièmement, cet argent devrait être donné en espèces, et certainement pas sous forme de points d'impôt. Troisièmement, cela devrait se faire dans le cadre d'un nouveau texte de loi parallèle à la Loi canadienne sur la santé. Théoriquement, la Loi canadienne sur la santé prévoit ces fonds pour les médecins et les hôpitaux. Cependant, en pratique, les provinces en font ce qu'elles veulent. Tout le monde joue sur les deux niveaux tout le temps. Dans la foulée, les citoyens ont perdu le sens de leurs droits, ce qui me paraît inacceptable dans le sens de l'imputabilité publique.

La nouvelle loi porterait sur les soins à domicile et les soins primaires, qui devraient constituer le noyau du système, mais qui ne sont pour l'instant qu'à sa périphérie. J'aimerais que nous y ajoutions une ou deux conditions. La première serait l'obligation de rendre compte.

La Loi canadienne sur la santé a été adoptée à un moment donné en avril 1984, et elle est entrée en vigueur le 1er juillet 1984. J'ai laissé ce portefeuille, et je savais depuis longtemps que je le laisserais, bien que personne d'autre ne l'ait su. Je me suis assurée que les règlements relatifs à l'exécution des pénalités seraient formulés et avalisés. Le processus a été fastidieux. Cependant, j'ai quitté la scène à ce moment-là. Je n'ai jamais vu d'autres règlements. À ce que j'ai compris, certaines dispositions des règlements n'ont même jamais été rédigées, ce qui m'amène à un article particulier de la loi que je trouve problématique. C'est celui qui traite de l'administration publique sans but lucratif, qui est l'une des cinq conditions.

Monsieur le président, ceci termine mes déclarations préliminaires, et je suis prête à répondre à vos questions.

Le président: Merci, madame Bégin. Avant de laisser la parole aux sénateurs, j'aimerais vous poser deux questions pour situer quelque peu le contexte. Je résisterai à la tentation, pour l'instant, de vous demander d'expliquer certaines de vos observations plus provocantes.

Two things have puzzled me about the Canada Health Act. One is that, of the five conditions, four of them, namely, universality, portability, accessibility and comprehensiveness, are all consumer-driven. They refer to the patient. The fifth condition, which is public administration, has always struck me as odd, in the sense that it refers to the means by which the other conditions will be met. I think that any system that met the conditions of universality, accountability, portability and comprehensiveness would be acceptable. I find it funny that the means of achieving the end has been elevated to the level of the others; or is it really of a different kind? I do not understand how it got there, other than the fact that it was in Emmett Hall's original report. Why was that maintained?

Ms Bégin: I was very young in the 1960s. I was not involved in politics then. I cannot even recall which ministers of health did it. I cannot answer you, Mr. Chairman.

You will have to go back to Malcolm Taylor, and I do not even know if he speaks of it. I do not remember that in his famous textbook.

I always thought that the first three that you named, and the fourth that I added, which you call consumer-driven, have to be consumer-driven because they give the citizens their entitlement. I cannot call it a right. It has nothing to do with rights. It is an agreed-upon privilege of our society to the taxpayers and citizens. They need to know that.

The Chairman: I agree with you that it is an entitlement. Most citizens have raised it to the level of a right, in the sense that it is how one thinks about medicare and the Canada Health Act.

Ms Bégin: The person who published the English version of my text wrote "the right to health." That is stupid. However, I discovered that when you write a book in one language you do not control the other language. It is not "the right to health." That does not exist. This involves philosophy, and many people do not function at that level.

The Chairman: You are saying that public administration began long before you got there and it was just maintained.

As someone who was in the market research business for a long time, if I was doing a survey and seeking public attitudes on what today's consumers wanted from the health care system, I think they would focus on three things. First, they would say they want quality health care, which is somewhat similar to comprehensiveness; second, they would want speed, in the sense that an element of quality is reasonably fast responsiveness to the system, which many Canadians would argue is not there now; and, third — and equally important to the other two — they would argue that they want the confidence that the system is economically sustainable in the long run. That is to say, they would like to know that the "insurance policy" that says that if

Deux choses m'ont laissé perplexe à propos de la Loi canadienne sur la Santé. La première est que sur les cinq conditions, quatre d'entre elles, soit l'universalité, la transférabilité, l'accessibilité et l'intégralité, visent le consommateur. Elles concernent le patient. La cinquième condition, qui est l'administration publique, m'a toujours semblé bizarre, dans le sens où elle se rapporte aux moyens de respecter les autres conditions. Je pense que n'importe quel système qui a pu répondre aux conditions d'universalité, d'imputabilité, de transférabilité et d'intégralité serait acceptable. Je trouve bizarre que les moyens d'arriver à ces fins aient été élevés au niveau des autres; ou est-ce en fait une condition d'un autre genre? Je ne comprends pas comment cela a pu se rendre là, à part le fait que c'était dans le rapport original d'Emmett Hall. Pourquoi cette condition a-t-elle été maintenue?

Mme Bégin: J'étais très jeune dans les années 60. Je ne faisais pas de politique à l'époque. Je ne peux même pas me rappeler qui ont été les ministres de la Santé de cette période. Je ne peux pas vous répondre, monsieur le président.

Il vous faudra relire Malcolm Taylor, et je ne sais même pas s'il en parle. Je ne me rappelle pas avoir vu cela dans son fameux traité.

J'ai toujours pensé que les trois premières conditions que vous avez données, et la quatrième que j'ai ajoutée, que vous dites vise le consommateur, sont bien obligées de viser le consommateur parce qu'elles donnent aux citoyens ce qu'il leur revient. Je ne peux pas appeler ça un droit. Cela n'a rien à voir avec les droits. C'est un privilège de notre société dont il a été convenu et dont jouissent les contribuables et les citoyens. Il faut qu'ils le sachent.

Le président: Je conviens avec vous que ça leur revient. La plupart des citoyens l'ont élevé au rang de droit, dans le sens où c'est ainsi que sont perçues l'assurance maladie et la Loi canadienne sur la santé.

Mme Bégin: La personne qui a publié la version anglaise de mon texte a écrit «the right to health». C'est idiot. Mais j'ai découvert que lorsque vous écrivez un livre dans une langue, vous ne contrôlez pas l'autre langue. Ce n'est pas un «droit à la santé». Ça n'existe pas. C'est un principe philosophique, et bien des gens ne pensent pas jusque là.

Le président: Vous dites que l'administration publique a commencé bien avant votre arrivée, et qu'elle est tout simplement été maintenue.

Comme j'ai longtemps travaillé dans le domaine de l'analyse des marchés, si je faisais un sondage pour cerner l'opinion du public sur ce que veulent les consommateurs du régime de soins de santé, je pense que les réponses tourneraient autour de trois facteurs. Premièrement, ils diraient qu'ils veulent des soins de santé de qualité, ce qui revient en quelque sorte à l'intégralité; deuxièmement, ils voudraient la rapidité, dans le sens où la réactivité raisonnablement prompte au système, que beaucoup de Canadiens jugeraient actuellement inexistante, serait un facteur de qualité; et troisièmement — et c'est tout aussi important que les deux autres — ils diraient qu'ils voudraient pouvoir se fier à la durabilité économique du système, à long terme. C'est-à-dire

they get sick they will be taken care of will not go bankrupt and will be there when they grow old.

From looking at public attitude data, what is undermining confidence in the system, perhaps more than any other single thing, is an unease that the system will not be there when people need it. That is to say, this “insurance policy element” is disappearing. Would you like to comment on that?

And if you think I am in the ballpark, does that mean that, for example, long-term sustainability should become a principle of a new Canada Health Act, or a new act, as you call it?

Ms Bégin: I think people want quality. If I were to add two criteria, I would say, first, accountability. “Quality” is a cosmetic word, because I do not know how you translate that operationally. While it is true that people want it, generally speaking, Canadians know they get quality because up to now the system has served Canadians rather well.

Concerning speed, I disagree with you. People want speed when they order pizza that is delivered within 15 minutes or else you are reimbursed, but I do not think the government wants to operate that way, or can. People have lots of tolerance. What they do not want is an unacceptable length of waiting time. They do not want a mess at the emergency room every Christmas season, but everyone knows how to “fix” and address that situation.

Sustainability is certainly a worry for Canadians. They want the system there when they need it. I never thought of the distinction that you made concerning the four conditions being consumer-driven. The fifth is an administrative concept, namely, the public administration of health care.

The Chairman: It is a means to an end.

Ms Bégin: Perhaps there should be a set of conditions concerning the operation of the system and sustainability. I think stability of funding from the federal government is a must. It is impossible to have healthy federal-provincial relations when the federal government suddenly makes cuts to the system, and so on. Having said that, the fiscal house had to be put in order. That is why Mr. Martin now has all those billions. I am neither commenting on the way it was done nor how it was done from 1984 on.

“Sustainability” means stability of funding. In the article that was published last week in “Policy Option,” I said that perhaps the cash contribution could be 25 per cent. That is a figure, not a prescription. It is an image of what could be. I think the tax points are gone; they are “lost”. Senator Robertson made the point to Marc Lalonde that, historically, the provinces had been robbed in the first place. I did not know that. I will go back and read about that, to see exactly how it happened.

qu’ils voudraient savoir que la «police d’assurance» où il est dit que s’ils tombent malades ils seront soignés, ne leur fera pas défaut et qu’elle existera encore lorsqu’ils vieilliront.

Si on regarde les données sur l’opinion publique, ce qui mine la confiance dans le système, plus, peut-être, que tout autre chose, c’est l’impression gênante que le système ne sera pas là lorsqu’on en aura besoin. C’est-à-dire que cet «élément de police d’assurance» s’évanouit. Pourriez-vous commenter cela?

Et si vous pensez que je vois juste, est-ce que cela signifie que, par exemple, la durabilité à long terme devrait devenir l’un des principes fondamentaux d’une nouvelle Loi canadienne sur la santé, ou de la nouvelle loi, comme vous l’appellez?

Mme Bégin: Je pense que les gens veulent de la qualité. Si je devais ajouter deux critères, je dirais, tout d’abord, l’imputabilité. Le mot «qualité» n’est qu’un terme esthétique, parce que je ne vois pas comment on peut le traduire dans le mode de fonctionnement. Bien qu’il soit vrai que c’est ce que veulent les gens, de façon générale, les Canadiens savent qu’ils ont la qualité, parce que jusqu’ici, le système les a plutôt bien servis.

Quant à la rapidité, je ne suis pas d’accord avec vous. Les gens veulent la rapidité lorsqu’ils commandent une pizza qui doit leur être livrée dans le quart d’heure qui suit, sinon elle est gratuite, mais je ne pense pas que le gouvernement veuille, ou même puisse, fonctionner ainsi. Les gens sont très tolérants. Ce qu’ils ne veulent pas, c’est une durée d’attente inacceptable. Ils ne veulent pas la pagaille dans les salles d’urgence à chaque saison des Fêtes, mais tout le monde sait comment «arranger» cela et régler cette situation.

La durabilité est certainement l’une des préoccupations des Canadiens. Ils veulent que le système soit là lorsqu’ils en ont besoin. Je n’ai jamais pensé à la distinction que vous faites, lorsque vous dites que les quatre conditions visent le consommateur. La cinquième condition est un concept administratif, c’est-à-dire l’administration publique du système de soins de santé.

Le président: C’est un moyen d’arriver à une fin.

Mme Bégin: Peut-être devrait-il y avoir une série de conditions relatives à l’exploitation du système et à sa durabilité. Je pense que la stabilité du financement provenant du gouvernement fédéral est un élément essentiel. Il est impossible d’avoir des relations harmonieuses entre le gouvernement fédéral et les provinces si le gouvernement fédéral impose soudain des compressions au système, et cetera. Ceci dit, il est nécessaire de faire le ménage dans la maison fiscale. C’est pourquoi M. Martin a maintenant tous ces milliards de dollars. Je ne commenterai pas la manière dont ça a été fait, ni dont c’est appliqué depuis 1984.

La «durabilité» signifie la stabilité du financement. Dans l’article qui a été publié la semaine dernière dans «Policy Option», j’ai dit que, peut-être, la contribution financière pourrait être de 25 p. 100. C’est un chiffre et non pas une prescription. C’est pour illustrer ce que ce pourrait être. Je pense que les points d’impôt sont choses du passé; ils sont «perdus». Le sénateur Robertson a bien dit à Marc Lalonde que, historiquement, les provinces avaient été flouées dès le départ. Je ne le savais pas. Je compte me renseigner à ce sujet, pour savoir exactement ce qui s’est passé.

The fight between the two levels of government concerning the figures is absolutely unproductive and counterproductive. They should agree to percentage X, and that should be the rule of the game. The provinces need stability of funding, and the public needs to know that it is there. It is absolutely essential that the public knows that as well.

The Chairman: That is the way you get the sustainability?

Ms Bégin: Yes.

Senator LeBreton: That is perfect. In the paper that you just referred to, you talk about the need for federal-provincial cooperation. The article concerns the whole issue of tax points. You say in this paper — and I am paraphrasing — that because tax points have been transferred to the provinces in 1977 and are lost forever to the feds we should not talk about them any more. In your comments, you said that citizens have lost their sense of entitlement.

This tax point issue is a huge football. The public is confused about it. The tax points represent money. I understand the point you make, but how do we get that back on the table? This is an excuse that is tossed back and forth between levels of government. There are tax points, yet the public does not have any sense of what the tax points mean or how they contribute. I know that we should not talk about them anymore, but how do we deal with them? How do we get into the public mind what those tax points actually represent, in terms of the delivery of the health care system?

Ms Bégin: I am suggesting that we stop talking about them in the sense that I feel — and Mr. Lalonde said the same in his testimony — that politics is the art of the possible. There are days that I hate the EPF. You have no idea. I lived a nightmare for years after because of something that was wrong with EPF, although I know the good sides of it. According to several political scientists, the 1970s was the decade of provincial affirmation. That continued into the 1980s. It is the art of the possible. Tax points were given, in a major way, to everyone.

I used the Canada Health Act with my idea that citizens will always be the defenders of medicare. If they do not like it, then it will disappear. I wanted accountability built in, so there is a clause that calls for the federal government to publish an annual report. That did not exist before. However, it does not mean much since the CHST. The lump sum transfer is even broader. The Auditor General has said bluntly that the federal government does not have a clue about what it gives to the provinces and for what.

There was some resistance inside Health Canada, but we created a column for tax points, a column for the value of the tax points, and a column for the cash and a total. I did my share of publicizing the whole sum in an effort to make the federal government accountable.

La lutte qui se déroule entre les deux ordres de gouvernement au sujet des chiffres est absolument improductive et va à l'encontre du but recherché. Ils devraient convenir d'un pourcentage, et ce devrait être la règle du jeu. Les provinces ont besoin de stabilité du financement, et le public a besoin de savoir que cette stabilité existe. Il est absolument essentiel que le public le sache aussi.

Le président: C'est comme ça que vous obtenez la durabilité?

Mme Bégin: Oui.

Le sénateur LeBreton: C'est parfait. Dans l'article que vous venez de mentionner, vous parlez de la nécessité d'une coopération entre le gouvernement fédéral et les provinces. L'article porte sur toute la question des points d'impôt. Vous dites dans cet article — je vous paraphrase — que parce que les points d'impôt ont été transférés aux provinces en 1977 et sont perdus pour toujours pour le gouvernement fédéral, nous ne devrions plus en parler. Dans vos observations, vous avez dit que les citoyens ont perdu le sens de ce qui leur revient.

Cette question de points d'impôt est un énorme ballon politique. Le public en est tout décontenancé. Les points d'impôt représentent de l'argent. Je comprends là où vous voulez en venir, mais comment faire pour ramener cela sur la table? C'est un prétexte que se renvoient les ordres de gouvernement de l'un à l'autre. Les points d'impôt existent, et pourtant le public ne sait absolument pas ce qu'ils signifient ni à quoi ils servent. Je sais que nous ne devrions plus en parler, mais comment devrions-nous les traiter? Comment faire comprendre au public ce qu'ils représentent pour la prestation des soins de santé?

Mme Bégin: Je propose que nous cessions d'en parler dans le sens où j'ai l'impression — et M. Lalonde l'a dit lui aussi dans son témoignage — que la politique est l'art du possible. Il y a des jours où je hais le PFE. Vous n'en avez pas idée. J'ai vécu un cauchemar pendant des années à cause de quelque chose qui clochait avec le PFE, même si j'en reconnais les bons côtés. D'après divers spécialistes politiques, les années 70 étaient la décennie de l'affirmation provinciale. Ça a continué dans les années 80. C'est l'art du possible. Les points d'impôt ont été attribués, fondamentalement, à toutes les provinces.

Je me suis servie de la Loi canadienne sur la santé en partant de mon idée que les citoyens seront toujours les plus grands défenseurs du régime de santé. S'ils ne l'aiment pas, il disparaîtra. Je voulais y intégrer le concept d'imputabilité, et c'est pourquoi il s'y trouve une disposition qui oblige le gouvernement fédéral à publier un rapport annuel. Cette disposition n'existait pas avant. Cependant, elle ne veut plus dire grand-chose depuis l'avènement du TCSPS. Le transfert forfaitaire est même plus vaste. Le vérificateur général a dit sans détours que le gouvernement fédéral n'a pas la moindre idée de ce qu'il donne aux provinces, ni pour quoi.

Il y a eu un peu de résistance au sein de Santé Canada, mais nous avons créé une colonne pour les points d'impôt, une colonne pour la valeur des points d'impôt et une colonne pour les transferts en espèces et un total. J'ai fait ma part pour diffuser le montant de la somme globale, dans un effort de reddition des comptes par le gouvernement fédéral.

That battle is now lost. First, that kind of fight between the two levels of government is a mess. Neither the provincial nor the federal administrators have any real concept of the costs involved in the health care system. Often the figures are blurred. It is political gamesmanship at its worst. This cannot go on.

The tax point system is what fuels best that counterproductive war of figures. If Senator Robertson is right historically, the matter reverts to the provinces and that is it. We do not speak of it any more.

Our country is one of the most decentralized federations in the world. The public always sees Ottawa as a big brother, but your researchers can provide you with the proportion of the tax capacity of the federal government to the provinces, which immediately after the war was something like 75 to 25 per cent. It is now the reverse. I would simply not speak of it.

I would set a cash floor in respect of what the federal government ought to commit itself. The federal government should not just seek political recognition, but in terms of straight accounting and accountability, value for money for programs should be attached as well.

Senator LeBreton: That is part of the problem. Some provinces say they are not getting the funding they used to, but then they will be told that they have tax points.

What about going back to a more open accountability of the tax points? Are you just suggesting establishing a new floor level and the tax points are just tax points? Where will they go? What is the solution?

Ms Bégin: The provinces will do what they want with it, the way they have always done since 1977.

I would just take the tax points out of the way. I think it poisons the whole thing and does not help at all. If it was bad politics, so be it. It was bad politics, but I still believe firmly that it was the only thing they could do at the time. Perhaps they should have given fewer tax points and more cash. I was not a party to the negotiations.

Senator LeBreton: I will just make a comment, if I may, that speaks to one excellent suggestion in your paper, where you advocate the creation of a council of health ministers with a permanent secretariat. It seems to me that some permanent body must continue. Otherwise, in 10 years, we will be going through this debate again.

Ms Bégin: The federal minister will never be able to tell them what to do and what not to do. Between peers, they could do a great job helping each other and reinforcing themselves.

Senator LeBreton: Previous witnesses have told us that the members of the public are tired of watching one level of government blame another level of government. They want it fixed.

Cette bataille est maintenant perdue. Tout d'abord, cette espèce de lutte entre les deux ordres de gouvernement a créé un véritable fouillis. Ni les gouvernements provinciaux, ni les administrateurs fédéraux n'ont la moindre idée du coût du régime de santé. Souvent, les chiffres sont brouillés. C'est l'art politique de la manœuvre à son pire. Ça ne peut pas continuer ainsi.

Le système des points d'impôt alimente cette guerre contre productive des chiffres. Si le sénateur Roberston ne se trompe pas sur la perspective historique, c'est l'affaire des provinces et un point c'est tout. N'en parlons plus.

Notre pays est l'une des nations les plus décentralisées du monde entier. Le public voit toujours dans Ottawa une espèce de big brother, mais vos attachés de recherche pourraient vous fournir la proportion du potentiel fiscal fédéral par rapport aux provinces, qui juste après la guerre se situait aux alentours de 75 p. 100 contre 25 p. 100. C'est maintenant l'inverse. Je n'en parlerais tout simplement plus.

Je fixerais un plancher des transferts en espèces auquel le gouvernement fédéral devrait s'engager. Il ne devrait pas seulement chercher la reconnaissance politique, mais par souci de comptabilité transparente et de reddition des comptes, il devrait aussi indiquer la valeur monétaire des programmes.

Le sénateur LeBreton: C'est en partie le problème. Certaines provinces soutiennent qu'elles n'ont plus le financement qu'elles recevaient auparavant, mais alors on leur rétorque qu'elles ont des points d'impôt.

Pourquoi ne pas revenir à une comptabilisation plus ouverte des points d'impôt? Est-ce que vous suggérez de fixer un nouveau plancher des transferts, et les points d'impôt ne sont que des points d'impôt? Où iront-ils? Quelle solution y a-t-il?

Mme Bégin: Les provinces en feront ce qu'elles veulent, comme elles l'ont toujours fait depuis 1977.

J'écarterais tout simplement les points d'impôt du chemin. Je pense qu'ils empoisonnent tout le système et n'aident à rien. S'il faut dire que c'était une mauvaise mesure politique, soit. C'était une mauvaise mesure politique, mais je continue de croire fermement que c'était la seule solution possible à l'époque. Peut-être auraient-ils dû donner moins de points d'impôt et plus d'espèces. Je n'ai pas assisté aux négociations.

Le sénateur LeBreton: Je n'ai qu'une observation à faire, si vous permettez, au sujet de l'une des excellentes suggestions que vous avez faites dans votre article, où vous prônez la création d'un conseil des ministres provinciaux de la Santé doté d'un secrétariat permanent. Il me semble nécessaire de maintenir un organe permanent. Autrement, dans une dizaine d'années, nous reprendrons ce débat à zéro.

Mme Bégin: Le ministre fédéral ne pourra jamais leur dire ce qu'ils doivent et ne doivent pas faire. Entre pairs, ils pourraient faire un travail fantastique en collaborant et en s'appuyant mutuellement.

Le sénateur LeBreton: Des témoins que nous avons entendus auparavant nous ont dit que le public en a assez d'entendre un ordre de gouvernement rejeter la faute sur un autre ordre de gouvernement. Les Canadiens veulent une solution.

Ms Bégin: There should still be federal-provincial meetings on policy and health. There is room for great initiatives, and many great opportunities were lost.

Senator Carstairs: The reality is, I think you are right. We have to stop fighting the war on tax points. It is over and done with; go away. To try to explain tax points to an audience, I am sure, as you have done, I have done it, everyone goes glassy-eyed. They do not know what you are talking about, and they never will, so forget it.

In your view, is there bargaining potential for accountability by granting more cash? For example, in return for the federal government increasing its contribution, which everyone recognizes must happen, can you bargain with the provinces to get the kind of accountability from them in reporting what they have spent the money on?

Ms Bégin: I was looking at the penalties of the first years of operation of the Canada Health Act. For me, the answer is yes. The level of funding by way of cash payments that is below 25 per cent, whatever it is, would still be ample for the federal government to have bargaining power and to ensure that they enforce whatever legislation presides, whatever new money they will offer, including the cash that remains under the CHST.

Senator Carstairs: We have decided we can get some accountability. Can we also negotiate for them to move into new programming? Home care or community-based care, whichever way you want to talk about, has been identified as a need in the society. The other area that has been highlighted is pharmacare, as we are moving more and more into drugs. I think you said drugs would replace surgery in many instances.

Can there be negotiations between politicians, where the feds will say, "Yes, we will give you moneys, but in order to achieve those moneys you must put more resources into community-based care and you must develop some form of pharmacare program"?

Ms Bégin: I was very sensitive to what Mr. Lalonde said about not taking the longer view, not falling into the trap of the short term and not building new rigidities into the system.

I cannot believe that 16 years ago we never thought the Alberta situation would occur, or the private and public MRIs next to each other in the Peel Hospital in Greater Toronto. That is kind of absolute nonsense in my opinion.

This is really a system in evolution. I do not have an answer; I am alone. I just bumped into the Auditor General, who was heading off to a committee to appear as a witness; 12 officials, with bags, accompanied him. How can I give you the operational answer? I do not know it. We should find a way. It is feasible. It should be discussed, first of all.

Mme Bégin: Il faudrait poursuivre les réunions fédérales provinciales sur la politique et la santé. Il y a de la place pour de grandes initiatives, et nous avons laissé passer beaucoup d'opportunités.

Le sénateur Carstairs: Le fait est que je vous donne raison. Il faut mettre fin à la guerre sur les points d'impôt. C'est fini, n'en parlons plus. Lorsqu'on tente d'expliquer les points d'impôt à un auditoire, je suis sûre que vous l'avez constaté comme moi, les regards deviennent fixes. Ils n'ont aucune idée de ce dont vous parlez, ils ne le sauront jamais, alors oublions cela.

D'après vous, y a-t-il possibilité de négocier la reddition des comptes en échange d'un financement accru? Autrement dit, en échange de l'augmentation des contributions du gouvernement fédéral qui, tout le monde en convient, est inévitable, est-ce que le gouvernement fédéral pourrait exiger des provinces qu'elles rendent des comptes en quelque sorte sur l'objet des dépenses?

Mme Bégin: Je crois que oui, si je me fie aux pénalités imposées au cours des premières années d'application de la Loi canadienne sur la santé. Même si le niveau de financement, sous forme de paiement en espèces, était inférieur à 25 p. 100, le gouvernement fédéral disposerait quand même d'une marge de manoeuvre suffisante pour négocier et faire en sorte qu'elles se mettent en oeuvre la loi en vigueur, peu importe l'argent neuf qu'il injecterait, y compris les montants prévus en vertu du TCSPS.

Le sénateur Carstairs: Nous tenons à ce qu'elles rendent des comptes. Pouvons-nous également négocier avec elles pour qu'elles mettent sur pied de nouveaux programmes? Nous avons besoin de soins à domicile ou de soins communautaires, appelez-les comme vous voulez. Il y a aussi la question de l'assurance-médicaments, les médicaments prenant une place de plus importante. Je pense que vous avez dit que les médicaments vont remplacer les chirurgies dans bien des cas.

Est-il possible de négocier entre politiciens, de dire, «Oui, nous allons vous donner l'argent, mais avant de l'obtenir, vous allez devoir investir davantage dans les soins communautaires et mettre sur pied un régime d'assurance-médicaments»?

Mme Bégin: Je suis d'accord avec ce qu'a dit M. Lalonde, qu'il faut regarder vers l'avenir, ne pas s'occuper uniquement du court terme, ne pas imposer de nouvelles contraintes au système.

Je ne peux pas croire que personne, il y a 16 ans, n'a envisagé la situation qui prévaut actuellement en Alberta, ou encore à l'hôpital Peel, dans la région métropolitaine de Toronto, où vous avez des services IRM offerts par des cliniques privées et publiques. C'est tout à fait insensé.

Notre système est en mutation. Je ne connais pas la réponse à la question; je suis venue toute seule. Je viens de croiser le vérificateur général, qui se rendait témoigner devant un comité. Il était accompagné d'une douzaine de fonctionnaires. Comment puis-je répondre à cette question? Je ne connais pas la réponse. Nous devrions trouver une solution. C'est faisable. Mais il faudrait d'abord en discuter.

We do not see much concrete discussion around the goals for which new money should be given. I do not know how to express it to be both general and flexible enough for the provinces to do it their way and to do so in a way that they feel it is their priority and at the same time to give back to Canadians a sense of their basic entitlements. This area needs to be studied.

Senator Keon: I would like to build on Senator Carstairs' questions and on something you said in your testimony, that we should not touch the Canada Health Act.

We all agree that it is too unsettling to the public to open up that act. However, let us use the act as a platform from which we can move into federal-provincial and community relations. Let us move beyond doctors and hospitals, out to the front end of prevention and population health, public health, toward home care and rehabilitation and such things.

I believe we could design systems with the kind of formula you describe, with the built-in cash from the federal government. We could have a co-operative system with a national context but provincial implementation, particularly as it relates to health care delivery.

The idea of private clinics is damaging to our system, not only because those clinics are private but because they operate from 9 to 5. Our public institutions are overrun on nights and weekends; they cannot handle the load. I do not just refer to imaging clinics and so forth. I mean health service clinics.

We have no mechanism right now for regulating that, but we could move off the platform of the Canada Health Act. We could build the pyramid and spill over the sides with various new programs that could come under our old-fashioned funding formula.

Learning from Senator Robertson, we cannot have an open-ended system where the provinces bargain. You are looking at me as though you are bewildered. I do want to hear your comments.

Ms Bégin: I am not sure I understood. Do you mean that we could update the Canada Health Act simply?

Senator Keon: No. We should leave the Canada Health Act as a platform. We can build a pyramid on the Canada Health Act. We can build vertically and horizontally. We can build in front-end programs such as universal population health, public health and so forth. We can build in back-end programs — rehabilitation and community programs.

Ms Bégin: Do you see that being done through legislation or just as a declaration of intent?

Senator Keon: That is what I want to hear from you.

Ms Bégin: Yes, I think ideally we should update and refine and enlarge the Canada Health Act, but it is not feasible for the political reasons that I mentioned. This is not partisan politics. It is the public view.

Or, il n'y a pas beaucoup de discussions sur les programmes auxquels on devrait affecter de l'argent neuf. Il faut trouver une formule à la fois générale et souple qui permet aux provinces d'agir de leur propre initiative, comme s'il s'agissait d'une priorité pour elles, tout en répondant aux besoins fondamentaux des Canadiens. C'est un domaine qu'il faut explorer.

Le sénateur Keon: J'aimerais revenir sur les questions qu'a posées le sénateur Carstairs et sur un commentaire que vous avez fait, soit qu'il ne faut pas toucher à la Loi canadienne sur la santé.

Il est vrai que le public verrait cela d'un mauvais oeil. Toutefois, nous devons nous servir de cette loi comme plate-forme pour établir des relations entre le fédéral, les provinces et les communautés. Nous devons porter notre attention non seulement sur les médecins et les hôpitaux, mais sur la prévention et la santé de la population, la santé publique, les soins à domicile, la réadaptation, ainsi de suite.

Je pense que nous pouvons arriver à créer des systèmes avec le genre de formule que vous proposez, avec le soutien du gouvernement fédéral. Nous pourrions avoir un régime national qui serait mis en oeuvre par les provinces, surtout qu'il traite de la prestation de soins de santé.

L'idée d'avoir des cliniques privées nuit à notre système, non seulement parce qu'elles sont privées, mais parce qu'elles fonctionnent de 9 à 5. Nos institutions publiques sont débordées le soir et la fin de semaine. Elles n'arrivent pas à répondre à la demande. Je ne fais pas seulement allusion ici aux cliniques qui offrent des services IRM, mais également aux cliniques de soins de santé.

Il n'existe pas de mécanisme pour réglementer ce genre de chose. Toutefois, nous pourrions utiliser la Loi canadienne sur la santé comme plate-forme, bâtir sur celle-ci une pyramide et y rattacher divers nouveaux éléments qui pourraient être financés en vertu de l'ancienne formule.

Comme l'a dit le sénateur Robertson, nous ne pouvons pas avoir un système extensible axé sur la négociation. Vous me regardez d'un air étonné. J'aimerais avoir votre opinion là-dessus.

Mme Bégin: Je ne sais pas si j'ai bien compris. Êtes-vous en train de dire qu'il suffirait tout simplement de réviser la Loi canadienne sur la santé?

Le sénateur Keon: Non. Elle servirait de plate-forme. Nous pourrions construire une pyramide sur celle-ci, non seulement de façon verticale, mais également horizontale. Nous pouvons mettre sur pied des programmes de première ligne, par exemple, sur la santé de la population, la santé publique, ainsi de suite. Nous pouvons également mettre sur pied des programmes secondaires qui mettent l'accent sur la réadaptation, les soins communautaires.

Mme Bégin: Et on le ferait au moyen d'une loi ou sur simple déclaration d'intention?

Le sénateur Keon: J'aimerais avoir votre opinion là-dessus.

Mme Bégin: L'idéal serait de réviser, de peaufiner la loi, d'en étendre la portée, mais cela n'est pas possible pour les raisons politiques que j'ai mentionnées. Il n'est pas question ici de politique partisane, mais de l'opinion publique.

What you describe as the pyramid, meaning programs of care before and after and other than in hospitals, should be part of a new parallel act, for lack of a better word. I wanted to convey that we should have the same rules of the game except that we should clarify the areas that are not clear in the Canada Health Act.

For me, the public administration clause is so general that no one can be against it. As it is now, at the top of a given province is the public administration, but then regional authorities can do what they want. There is a complete disconnection there.

Speaking of private/public, by the way, we should discuss "for profit" and "not for profit." There are many pieces of the health care system that are already "private." In the very early 1980s or earlier, hospitals went private with their laundry services, then the food services, then the labs. Many labs in our system are privately run.

My doctor wanted a battery of tests done. I went to a place called Dynacare, where they process patients like sausages. I hope and I am sure they do an excellent job in their scientific assessments and measurements.

I checked with some health economists. Not one single evaluation study was conducted on any of the privatization measures that I have just mentioned. It was assumed that privatization of those services was cheaper and more productive. We all think but do not say it — privatization frees us from union rules that are far too rigid. That is for sure.

Mr. Lalonde gave the example of the nurse who cannot be moved from one floor to the next. That is one of many examples and it is a pity.

We know instinctively that going private for food and kitchen and laundry — and maybe labs, I do not know — will not put medicare as a public system in danger, but, somehow, the next step will. I wish I knew the full rules of the game by which certain things just will not work, but I do not.

I am not privy to any intelligence here, but I read in the newspaper of a hospital — I think it is in Peel County — where they had as neighbours a private MRI and a public MRI. That makes no sense whatsoever. That is contradictory in logic. The logic of profit and the logic of the private good just do not work together.

The future clinics in Alberta are the same. The physicians will be accredited to public hospitals and to private clinics. Where will they go? Human nature being what it is, the doctors will go where the pay is higher. It is elementary.

The main question to be discussed, explored and resolved by making new rules of the game is where to allow for-profit work and where to keep public work only.

Ce que vous décrivez comme étant une pyramide, c'est-à-dire des programmes de soins offerts hors du milieu hospitalier, devrait faire partie d'une nouvelle loi parallèle, à défaut de meilleur terme. Nous devrions garder les mêmes règles du jeu, sauf que nous devrions clarifier les dispositions de la Loi canadienne sur la santé qui sont nébuleuses.

Par exemple, la disposition sur l'administration publique est tellement générale que personne ne peut s'y opposer. À l'heure actuelle, il y a dans chaque province, au haut de l'échelle, l'administration publique, sauf que les autorités régionales sont libres d'agir à leur guise. Cela n'a aucun sens.

En ce qui a trait aux cliniques privées et publiques, nous devrions avoir une discussion sur ce que nous entendons par «à but lucratif» et «sans but lucratif». De nombreux services de santé sont déjà «privés». Au début des années 80, et même avant, les hôpitaux ont d'abord commencé à privatiser leurs services de blanchisserie, suivis des services d'alimentation et ensuite des laboratoires. De nombreux laboratoires dans le système sont privés.

Mon médecin a voulu me faire subir une batterie de tests. J'ai dû me rendre dans une clinique appelée Dynacare, où les patients sont traités à la chaîne. J'espère, et je suis certaine, qu'elles font de l'excellent travail.

Je me suis renseignée auprès de certains économistes de la santé et j'ai appris que les mesures de privatisation que j'ai mentionnées n'ont jamais fait l'objet d'une étude d'évaluation. On est parti du principe que ces services, en les privatisant, coûteraient moins cher et seraient plus productifs. Nous le pensons tous, mais nous ne le disons pas — la privatisation nous libère des règles syndicales qui sont trop rigides. C'est un fait.

M. Lalonde a parlé du cas de l'infirmière qui ne peut être déplacée d'un étage à l'autre. C'est un exemple parmi tant d'autres, et c'est dommage.

Nous savons que la privatisation des services d'alimentation et de blanchisserie — peut-être des laboratoires, je ne sais pas — ne compromet pas le régime public de soins de santé. Toutefois, la situation risque de changer. Si je connaissais toutes les règles du jeu, je pourrais vous dire quand arrêter, mais je ne les connais pas.

J'ai lu, dans un journal, un article sur un hôpital — je pense qu'il est situé dans le comté de Peel — qui est voisin de deux cliniques qui offrent des services IRM: une privée et une publique. Cela n'a aucun sens. C'est illogique. Profit et bien privé sont deux notions contradictoires.

Il en va de même pour les nouvelles cliniques qui ouvriront leurs portes en Alberta. Les médecins pourront pratiquer et dans les hôpitaux publics et dans les cliniques privées. Où vont-ils aller? La nature humaine étant ce qu'elle est, ils vont aller là où ils vont gagner le plus, c'est évident.

La question centrale qu'il faut se poser, explorer et régler en établissant de nouvelles règles du jeu est la suivante: où tracer la ligne entre recherche du profit et bien public.

The Shouldice Hospital in Toronto is a special historical exception to the creation of medicare but one that is totally acceptable, as far as I know. That issue must be clarified.

The Chairman: I want to be sure I understand your point and that made by Senator Keon. You speak of building on the base of the Canada Health Act and broadening its coverage. Federal politicians for decades have talked about the federal role in the health care system. The federal government has never been in the broad health care system in the same way the public perceives the health care system. The federal government finances hospitals and doctors, not the health care system, per se.

Ms Bégin: In two avenues, which are now changing, the federal government acted as a provincial minister of health — that is, in veterans health and in aboriginal health.

The Chairman: In the broader sense, though, the term “health care,” when used by a federal government spokesperson or when read by the average citizen, includes everything — drugs, home care, long-term care. The federal government has never really acted at that broad level of health care. It has only been involved with hospitals and doctors.

You seemed to respond to the premise underlying Senator Keon's question by saying that it is about time we had an act that defined the federal government's role in health care in the broader sense, not merely in the sense of hospitals and doctors. We can leave the cornerstone of hospital and doctors, but we should enlarge on it. Is that what the two of you were saying essentially?

Ms Bégin: I cannot speak for Dr. Keon. I will let him answer.

What you say is too black and white to reflect the evolution of the health care system. When it was created, it was just about hospitals and doctors. We did not know anything else — that is what health care was. Read the preamble of the Canada Health Act, which is new. It goes further than that. I, however, did not have time to re-read it before this meeting. I made sure that it expressed the philosophy of health care the way Marc Lalonde presented it when he appeared here before you. I was pleased with my preamble because we modernized without creating any problems with the provinces. Something I understood after the fact is that it seems that the preamble has no validity in law. If my memory serves me well, the preamble contains a very modern definition of health, except that it is not operational. Do you see what I mean?

The Chairman: Senator Keon, do you want to comment on my observation, or did I understand you correctly?

Senator Keon: I think you summarized fundamentally the concept. I wanted Ms Bégin's response to that concept.

Ms Bégin: Federally, a broader definition has always existed. Times are changing. It is not encapsulated in legislation.

L'Hôpital Shouldice, à Toronto, constitue une exception à la règle, pour ce qui est du régime de soins de santé, mais une exception qui, en ce qui me concerne, est totalement acceptable. Son statut doit toutefois être clarifié.

Le président: Je veux voir si j'ai bien compris votre position et celle du sénateur Keon. Vous parlez de renforcer les fondements de la Loi canadienne sur la santé, d'en étendre la couverture. Les politiciens fédéraux parlent depuis des décennies du rôle joué par le gouvernement fédéral dans le système de soins de santé. Or, il n'a jamais joué dans celui-ci un rôle très vaste, comme le perçoit le public. Il finance les hôpitaux et les cabinets de médecins, pas les soins de santé en tant que tels.

Mme Bégin: Il y a deux domaines où le gouvernement fédéral a agi en qualité de ministre provincial de la santé — soit la santé des anciens combattants et celle des Autochtones.

Le président: Toutefois, de façon générale, l'expression «soins de santé», quand elle est utilisée par un porte-parole du gouvernement fédéral ou par le simple citoyen, englobe tout — les médicaments, les soins à domicile, les soins à long terme. Le gouvernement fédéral n'a jamais joué un rôle très vaste à ce chapitre. Il ne s'occupe que des hôpitaux et des cabinets de médecins.

Vous semblez dire, en réponse au principe qui sous-tend la question du sénateur Keon, qu'il est temps d'adopter une loi qui définit bien le rôle que joue le gouvernement fédéral de manière générale, un rôle qui ne se limite pas au financement des hôpitaux et des cabinets de médecins. Nous pouvons garder ces composantes, mais nous devrions élargir son rôle. C'est bien ce que vous dites tous les deux?

Mme Bégin: Je ne peux parler au nom du docteur Keon. Je vais le laisser répondre.

Vous ne tenez pas compte, dans vos propos, de l'évolution qu'a connue le régime de soins de santé. Quand il a été créé, il ne visait que les hôpitaux et les cabinets de médecins. Point à la ligne — c'était comme cela qu'on voyait les soins de santé. Je vous invite à lire le préambule de la Loi canadienne sur la santé, qui est nouveau. Il va encore plus loin. Je n'ai pas eu le temps de le relire avant la réunion. Je tenais à ce qu'il reflète les principes qui sous-tendent les soins de santé. Marc Lalonde en a parlé quand il a comparu devant vous. J'étais satisfaite de mon préambule parce que nous avons réussi à moderniser la loi sans que cela ne crée des problèmes avec les provinces. Toutefois, j'ai compris, après coup, que le préambule n'a aucune validité juridique. Si je me souviens bien, le préambule contient une définition actualisée de la santé, sauf qu'elle n'est pas appliquée. Comprenez-vous ce que j'essaie de dire?

Le président: Sénateur Keon, est-ce que je vous ai bien compris?

Le sénateur Keon: Je pense que vous avez bien résumé le concept. Je voulais voir ce que Mme Bégin en pensait.

Mme Bégin: On a toujours utilisé une définition plus vaste au niveau fédéral. Les temps changent. Elle n'est pas inscrite dans la loi.

The Chairman: Senator Callbeck is not only a former premier of Prince Edward Island, she was the provincial minister of health at the same time that Madam Bégin was the federal minister of health.

Senator Callbeck: Ms Bégin, it is great to see you again. I want to come back to the funding to the provinces. Did I understand that you are advocating going back to a cost-shared system? You mentioned the feds paying 25 per cent of total health expenditures.

Ms Bégin: I understand what you are saying. I do not recommend going back to the cost-shared system that existed, where the provinces called the shots and the feds reimbursed one-half of them. I am not completely clear in my own mind yet as to how to do it. However, the provinces would have to agree with the feds as to a kind of global national envelope for health care. Of course, using the percentage of GDP is not the perfect measure.

I have to think it through more. For instance, if there is a global envelope, then the feds will transfer a lump sum. That global envelope will increase with the years. Hence, it is not a cost-shared system, in the sense that the feds control it. They still keep the notion of EPF, which is the transfer of a lump sum. That is what is done right now. A base year was chosen. I think it was 1975 or 1976.

Senator Callbeck: I think it was 1975.

Ms Bégin: They all agreed on what it cost them. Those who felt badly treated received equalization or a way to catch up. Everyone agreed on the base year. A mathematical formula was arrived at, by which it would increase by population growth, GDP, and a third indicator, which escapes me right now.

I should like to find out from someone who knows how it came to be understood by the main actors that the cash would never be more than 25 per cent. That should be verified. Certainly, there is a definition of what the cash would be in proportion to the non-cash.

Senator Callbeck: Just to get it clear in my own mind, there is an envelope of money provided by the federal government, and that envelope is divided among the provinces. Will the federal government tell the provinces that that must be spent on health expenditures, or will it be flexible like it is right now?

Ms Bégin: It is clear to me that there is no way we can come back on the big chunk of that money, which is the tax points. Someone, somewhere, has to be inventive in devising a system of accountability around a few goals and general ideas as to what that new money is for. I do not think you can touch the past. For me, the past is the past, for the reasons I have just explained. A huge chunk of the cost of the total bill for health in a given province comes from the transfer of federal tax points. Then there

Le président: Le sénateur Callbeck a non seulement été élu premier ministre de l'Île-du-Prince-Édouard, mais elle a également occupé le poste de ministre provinciale de la santé à l'époque où Mme Bégin était ministre fédérale de la santé.

Le sénateur Callbeck: Madame Bégin, je suis contente de vous revoir. Je voudrais revenir à la question du financement des provinces. Vous avez bien dit que vous souhaitez qu'on revienne à un système à frais partagés? Vous avez dit que le gouvernement fédéral payait 25 p. 100 des dépenses totales consacrées aux soins de santé.

Mme Bégin: Je vois où voulez en venir. Je n'ai pas recommandé qu'on revienne à l'ancien système à frais partagés où les provinces prenaient les décisions et le gouvernement fédéral assumait la moitié des dépenses. Je ne sais pas encore comment nous devrions procéder. Toutefois, il faudrait que les provinces s'entendent avec le gouvernement fédéral sur l'enveloppe globale qu'il faudrait consacrer à l'échelle nationale aux soins de santé. Consacrer un pourcentage du PIB aux soins de santé n'est pas la solution idéale.

Il faut que j'analyse la question plus à fond. Par exemple, s'il y a une enveloppe globale, alors le gouvernement fédéral y transférerait une somme forfaitaire. Cette enveloppe augmenterait au fil des ans. Par conséquent, on ne pourrait parler d'un système à frais partagés puisque c'est le gouvernement fédéral qui le contrôlerait. Il continuerait d'appliquer la formule FPE, qui prévoit le transfert d'une somme forfaitaire. C'est ce qu'on fait à l'heure actuelle. On a choisi une année de référence. Je pense que c'est 1975 ou 1976.

Le sénateur Callbeck: Je pense que c'était 1975.

Mme Bégin: Ils se sont tous entendus sur ce que leur coûtaient les soins de santé. Ceux qui s'estimaient lésés avaient droit à des paiements de péréquation. Tout le monde s'est entendu sur l'année de référence. On a élaboré une formule en vertu de laquelle les transferts augmenteraient en fonction de la croissance de la population, du PIB et d'un troisième critère qui, pour l'instant, m'échappe.

J'aimerais que quelqu'un m'explique comment les principaux intéressés sont arrivés à la conclusion que les transferts en espèces ne représenteraient jamais plus de 25 p. 100 des dépenses. Il faudrait vérifier cela. On avait sûrement défini en quoi consistaient les transferts au comptant par rapport aux autres.

Le sénateur Callbeck: Si j'ai bien compris, il y a une enveloppe fournie par le gouvernement fédéral, et cette enveloppe est divisée entre les provinces. Est-ce que le gouvernement fédéral va dire aux provinces qu'elles doivent consacrer cet argent aux soins de santé, ou va-t-il faire preuve de souplesse, comme c'est le cas à l'heure actuelle?

Mme Bégin: Il est évident que nous ne pouvons pas toucher aux transferts de points d'impôt. Il faut établir un mécanisme de responsabilité qui s'appuie sur de nouveaux objectifs, trouver de nouvelles façons d'utiliser l'argent neuf. On ne peut pas changer le passé. Pour moi, le passé, c'est le passé, pour les raisons que je viens de vous expliquer. Les points d'impôt comptent pour une bonne part des coûts des soins de santé des provinces. Il y a ensuite la contribution des provinces — personne n'est en mesure

is their share — and nobody knows what that is. It is a great deal, but it differs from province to province in terms of what it covers.

Then there is the federal cash. There will be new money. I have read in the newspapers, which I trust, that the Minister of Health, the Minister of Finance and the Prime Minister have assured Canadians that as soon as they all agree on what reform should take place — and it should take place — they will have new money. I start from that idea.

The Chairman: If the federal government were to give more money, how could there be an accountability mechanism? Perhaps you would not go back to the detailed 50-50 formula. By “detailed”, I mean that it was micromanaged. On the other hand, by its very nature, block funding, with no strings attached, has no penalty mechanism.

Ms Bégin: It has enforcement mechanisms and penalties right now. I am talking about health, not post-secondary education.

The Chairman: That is right. Even if the federal amount is raised, it will be a small enough piece that it is not clear to me that the funding mechanism —

Ms Bégin: Billions are billions are billions. I assure you that the provinces understand the language of money very well, as I do.

The Chairman: Do you think the federal government can impose enough conditions to make accountability work?

Ms Bégin: When we speak of conditions, they cannot and should not be rigid operational conditions.

The Chairman: I agree.

Ms Bégin: They are general, consumer-driven principles or standards, which is totally legitimate constitutionally. They give an amount of cash to achieve these results.

The Chairman: Has anyone you know of looked at the question of what those results, outcomes, what I am calling conditions, might be? We have not seen any evidence on that. This is assuming the federal government goes down this road.

Ms Bégin: In the context of discussing the Canada Health Act the way we are, no, I do not know anyone who has done that. However, in that regard, your committee should hear from the former deputy minister of health of Ontario, who does excellent work at CIHI. At times, I feel like asking him why he did not do all that when he was deputy minister of health for Ontario, but I have not asked him.

[Translation]

Senator Gill: I come from a rural area and I am an aboriginal. I realize that health care programs are administered by Health Canada. Generally speaking, aboriginal communities are remote and located some distance from large urban centres. Health care is beyond our control and costs are astronomical. I do not foresee the day when the financial situation will get any better.

de la chiffrer. Elle est importante, mais elle varie d'une province à l'autre.

Il y a aussi les fonds versés par le gouvernement fédéral. Il y aura de l'argent neuf. J'ai lu dans les journaux, que je qualifie de sérieux, que le ministre de la Santé, le ministre des Finances et le premier ministre ont laissé entendre aux Canadiens que, dès que tout le monde se sera entendu sur les réformes qui doivent — et qui devraient — être apportées, de l'argent neuf sera investi dans le système. C'est un point de départ.

Le président: Si le gouvernement fédéral injectait plus d'argent dans le système, quelle forme prendrait alors le mécanisme de responsabilité? On ne reviendra pas à la formule complexe de 50-50. Par «complexe», je veux dire qu'elle était gérée à outrance. Par ailleurs, de part sa nature, le financement global, sans condition aucune, ne prévoit aucun mécanisme de pénalité.

Mme Bégin: Il existe à l'heure actuelle des mécanismes de mise en oeuvre et des pénalités. Je parle de soins de santé, pas d'éducation postsecondaire.

Le président: C'est vrai. La contribution fédérale, même si elle augmente, ne sera pas à ce point importante, et je ne vois pas comment le mécanisme de financement...

Mme Bégin: Il est question ici de milliards dollars. C'est un langage que comprennent bien les provinces. Moi aussi d'ailleurs.

Le président: Pensez-vous que le gouvernement fédéral peut imposer suffisamment de conditions pour les obliger à rendre compte de l'utilisation des fonds?

Mme Bégin: Les conditions ne doivent pas, et ne devraient pas, être rigides.

Le président: Vous avez raison.

Mme Bégin: Il existe des principes généraux, axés sur le consommateur, qui sont tout à fait légitimes du point de vue constitutionnel. Ils versent de l'argent pour obtenir ces résultats.

Le président: Savez-vous si on a déjà cherché à savoir quels devraient être ces résultats, ces conditions? Nous n'avons rien vu sur le sujet. En supposant, bien entendu, que c'est ce que fera le gouvernement.

Mme Bégin: Je ne connais personne qui se soit penché là-dessus, en tout cas pas dans le contexte de la Loi canadienne sur la santé. Toutefois, votre comité devrait convoquer l'ancien sous-ministre de la santé de l'Ontario, qui fait de l'excellent travail auprès de l'ICIS. J'ai parfois envie de lui demander pourquoi il n'a pas fait tout cela quand il était sous-ministre de la santé de l'Ontario. Je n'ai pas osé lui poser la question.

[Français]

Le sénateur Gill: Je viens de la campagne et je suis d'origine autochtone. Je sais que les soins de santé sont gérés par la santé nationale fédérale. En règle générale, on vit dans des endroits isolés, assez éloignés des grands centres. Les soins de santé y sont hors contrôle et les budgets épouvantables. Je ne vois pas le jour où la situation financière va s'améliorer.

For some time now, people have been stripped of their responsibilities. Centralization appears to be the order of the day, not just when it comes to health care, but also in the field of education. Given technological developments and advances, the need to centralize is understandable. However, people have been stripped of certain responsibilities.

For example, in my part of the country, Northern Quebec, transportation costs in remote areas are very high and direct health care is not available. Repercussions are inevitable. Even though the federal government does not have jurisdiction over health care everywhere, people should be made to assume more responsibilities. Many kinds of care can be provided at home. When I was a young man, a number of illnesses were treated at home.

While I am not a health care expert, I do believe that we need to get back to basics and provide health care at the local level, so that people do not have to travel to receive treatment. There are many people in the community with medical knowledge and skills, and I am not just talking about aboriginal communities.

Ms. Bégin: Our health legislation makes no mention of the concept of responsibility and I think this should change. However, I am not really sure how we could go about introducing this concept and how it would apply.

Supposing a provision in a future piece of legislation refers to individual responsibility. What if this provision were invoked in the case of obese individuals, people with lung cancer and young persons seeking to have a tattoo removed? I do not agree that these individuals should be punished for behaviour deemed irresponsible. I do not favour this kind of accountability. I believe education is the key to making people more responsible. I would be leery about invoking such a provision, although I agree that perhaps mention should be made of the concept in the act's preamble.

Your question gives me the opportunity to mention that aboriginal health care presents new challenges for our society. Demographically speaking, many aboriginals live off of reserves. The provinces and the federal government are waging hidden battles over who should pay for aboriginal health care.

I have encountered some unlikely situations and have had to negotiate and resolve some incredible problems. I would also like to mention that I am responsible for bringing about the devolution of health care services to aboriginal communities. Initially, the Community Healthcare Workers' initiative was launched, with workers being band members. However, this approach was not very effective.

Subsequently, reserves were allowed to select where they wanted residents sent for treatment. Many residents chose the Royal Victoria or Mount Sinai and obviously, that was impractical. Then they were allowed to select various health care services and programs.

Par contre, depuis un certain temps on déresponsabilise les gens, on centralise beaucoup et ce, pas uniquement dans le secteur de la santé, mais également en éducation. Avec le développement de la technologie et des spécialités, il est compréhensible qu'on ait besoin de centraliser. On a enlevé certaines responsabilités aux gens.

Dans les endroits isolés, par exemple dans mon coin, au Nord du Québec, le transport est très dispendieux et les soins ne sont pas directement donnés. Tout cela entraîne des conséquences. Même si la santé n'est pas de juridiction fédérale partout, les gens devraient être davantage responsabilisés. Beaucoup de soins peuvent être donnés à domicile. Quand j'étais jeune, on se soignait beaucoup de certains maux à la maison.

Sans être un spécialiste de la santé, je pense qu'on devrait revenir aux sources et prodiguer des soins de façon locale pour empêcher les gens de se déplacer. Dans les communautés plusieurs ont des connaissances médicales. Je ne parle pas seulement des autochtones, je parle de l'ensemble des communautés.

Mme Bégin: Nos lois sur la santé ne stipulent pas la notion de responsabilité et je crois qu'elle devrait être introduite. J'ignore à quel titre elle pourrait être introduite et je ne vois pas comment elle peut être mise en œuvre.

Supposons que la notion de responsabilité devient un paragraphe de la future loi, si elle est utilisée un jour contre les gens obèses, contre ceux qui sont atteints du cancer du poumon et contre les jeunes qui veulent se faire enlever des tatouages, je ne serais pas d'accord qu'on veuille punir ces gens pour des comportements qu'on juge non responsables. Je ne fais pas partie des gens qui militent pour ce type de responsabilisation. Je crois que c'est par l'éducation qu'on responsabilise les gens. Je me méfierais de l'usage éventuel de ce concept, mais je suis d'accord à ce qu'il figure dans le préambule de la loi.

J'aimerais profiter de votre question pour mentionner que la santé des autochtones pose de nouveaux défis à notre société. Au sens démographique, il y a l'incroyable mobilité des autochtones qui vivent en dehors des réserves. Il y a également des batailles cachées entre les provinces et le fédéral, à savoir qui devra payer pour eux.

J'ai vu des scènes invraisemblables que j'ai dû vivre, tâcher de négocier et résoudre. Je veux aussi mentionner que j'ai mis en œuvre la dévolution des services de santé aux communautés autochtones. On a fait une erreur au début, on avait créé les Community Healthcare Workers et ces gens faisaient partie de la réserve. Ce type d'aide n'a pas vraiment fonctionné.

Par la suite, les réserves pouvaient choisir l'endroit où elles voulait aller se faire soigner. Plusieurs réserves choisissaient le Royal Victoria ou le Mount Sinai situé dans une quelconque réserve. Évidemment, cela est impensable. Par contre, les réserves pouvaient choisir plusieurs des services ou des programmes de santé.

I never conducted a study as such, but as a recall, reserves opted mainly for services such as detoxification centres and small programs associated with day-to-day life. I am not aware of the current situation but I have observed that aboriginal communities are experiencing phenomenal growth. More aboriginals are moving to large urban areas every day. Prescription drug abuse is also a problem. Moreover, the Auditor General alluded to it in his report.

There is nothing more that I can say about making people accountable. Obviously, society must work to make people accountable at all levels. Other resources and services are available, aside from hospitals, to help people maintain good health and to prevent and treat illness.

Why are Quebec's CLSCs not open 24 hours a day, seven days a week? Doctors working in teams could sign a contract with their province and abide by the rules of the game. Obviously, a different kind of health care is needed in remote regions.

[English]

The Chairman: Thank you very much. Senators, we must adjourn. We have a vote in 12 minutes. We will continue our session with Ms Bégin as soon as we are able to arrange another mutually convenient time, and our first questioner will be Senator Robertson.

Thank you very much for attending here this afternoon. We look forward to round two.

The committee adjourned.

Je n'ai jamais fait d'études, mais de mémoire les réserves ont surtout choisi des maisons de désintoxication, de petits programmes liés à la vie quotidienne. Je ne connais pas la situation actuelle, mais je vois l'extraordinaire explosion démographique de la communauté autochtone. Le mouvement vers les grands centres s'accroît tous les jours un peu plus. On remarque également des abus pharmaceutiques. Le vérificateur général en a d'ailleurs touché un mot dans son rapport.

Sur la notion de responsabilité, je ne peux rien dire de plus. Il est évident que la responsabilisation des gens constitue un projet de société et elle se fait à tous les niveaux. Il existe toute une gamme de services, autres que les hôpitaux, pour maintenir la santé, prévenir la maladie, et guérir.

Au Québec, comment se fait-il que les CLSC ne sont pas ouverts 24 heures sur 24, sept jours par semaine? On pourrait voir des médecins travaillant en groupe, qui acceptent les règles du jeu et qui reçoivent un contrat de leur province. Évidemment, en région isolée, c'est un tout autre type d'aide qui doit être inventé.

[Traduction]

Le président: Merci beaucoup. Sénateurs, nous devons suspendre la séance. Nous devons participer à un vote dans une douzaine de minutes. Nous poursuivrons la discussion avec Mme Bégin dès que nous aurons convenu d'une date. Le sénateur Robertson sera la première intervenante.

Merci d'être venue nous rencontrer cet après-midi. Nous avons bien hâte de reprendre la discussion.

La séance est levée.



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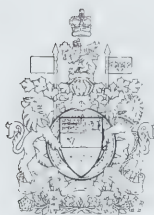
WITNESS—TÉMOIN

As an individual:

The Honourable Monique Bégin, P.C.

À titre personnel:

L'honorable Monique Bégin, c.p.



Second Session
Thirty-sixth Parliament, 1999-2000

SENATE OF CANADA

*Proceedings of the Standing
Senate Committee on*

Social Affairs, Science and Technology

Chairman:
The Honourable MICHAEL KIRBY

Wednesday, June 7, 2000

Issue No. 17

Twelfth meeting on:
The state of the health care system in Canada

INCLUDING:
THE SEVENTH REPORT OF THE COMMITTEE:
The developments since the tabling in June 1995
of the final report of the Special Senate Committee
on Euthanasia and Assisted Suicide
entitled, "Of Life and Death"

WITNESS(ES):
(See back cover)

Deuxième session de la
trente-sixième législature, 1999-2000

SÉNAT DU CANADA

*Délibérations du comité
sénatorial permanent des*

Affaires sociales, des sciences et de la technologie

Président:
L'honorable MICHAEL KIRBY

Le mercredi 7 Juin 2000

Fascicule n° 17

Douzième réunion:
L'état du système de santé au Canada

Y COMPRIS:
LE SEPTIÈME RAPPORT DU COMITÉ:
Les faits nouveaux survenus depuis le dépôt, en
juin 1995, du rapport final du comité sénatorial spécial
sur l'euthanasie et l'aide au suicide intitulé:
«De la vie et de la mort»

TÉMOIN(S):
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Cook
Beaudoin	Corbin
* Boudreau, P.C.	Ferretti Barth
(or Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Robertson

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Banks substituted for that of the Honourable Senator Pépin (*June 6, 2000*).

The name of the Honourable Senator Ferretti Barth substituted for that of the Honourable Senator Gill (*June 6, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Banks	Cook
Beaudoin	Corbin
* Boudreau, c.p.	Ferretti Barth
(ou Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Robertson

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Banks est substitué à celui de l'honorable sénateur Pépin (*le 6 juin 2000*).

Le nom de l'honorable sénateur Ferretti Barth est substitué à celui de l'honorable sénateur Gill (*le 6 juin 2000*).

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, June 7, 2000
(24)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in Room 705, Victoria Building, at 3:33 p.m., the Chair, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Banks, Callbeck, Kirby, LeBreton, Robertson (5).

Other senator present: The Honourable Senator Fairbairn.

In attendance: From the Research Branch of the Library of Parliament: Odette Madore

Also in attendance: The official reporters of the Senate.

WITNESSES:

From the Department of Finance:

Guillaume Bissonnette, General Director, Federal-Provincial Relations and Social Policy Branch;

Barbara Anderson, Director, Federal-Provincial Relations Division, Federal-Provincial Relations and Social Policy Branch.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference, see proceedings of the committee, Issue No. 8.*)

The Chair made a statement.

Mr. Bissonnette made a statement and, together with Ms Anderson, answered questions.

At 5:04 p.m., the committee adjourned to the call of the Chair.

ATTEST:

PROCÈS-VERBAL

OTTAWA, le mercredi 7 juin 2000
(24)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 15 h 33, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Banks, Callbeck, Kirby, LeBreton et Robertson (5).

Autre sénateur présent: L'honorable sénateur Fairbairn.

Également présente: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

TÉMOINS:

Du ministère des Finances:

Guillaume Bissonnette, directeur général, Direction générale des Relations fédérales-provinciales et de la politique sociale;

Barbara Anderson, directrice, Division des relations fédérales-provinciales, Direction générale des relations fédérales-provinciales et de la politique sociale.

En conformité avec l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale de l'état du système de santé au Canada. (*Le texte intégral de l'ordre de renvoi figure dans les délibérations du comité, fascicule n° 8.*)

Le président prononce un mot de bienvenue.

M. Bissonnette fait un exposé, puis, avec l'aide de Mme Anderson, répond aux questions.

À 17 h 04, le comité s'ajourne jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

REPORT OF THE COMMITTEE

TUESDAY, June 6, 2000

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to table its

SEVENTH REPORT

Your Committee, which was authorized by the Senate on Thursday, November 25, 1999 to examine and report upon developments since the tabling in June 1995 of the final report of the Special Senate Committee on Euthanasia and Assisted Suicide, entitled: *Of Life and Death*, now tables its final report entitled: *Quality End-of-Life Care: The Right of Every Canadian*.

Respectfully submitted,

RAPPORT DU COMITÉ

Le MARDI 6 juin 2000

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de déposer son

SEPTIÈME RAPPORT

Votre Comité, qui a été autorisé par le Sénat le jeudi 25 novembre 1999 à examiner, pour en faire rapport, les faits nouveaux survenus depuis le dépôt, en juin 1995, du rapport final du Comité sénatorial spécial sur l'euthanasie et l'aide au suicide, intitulé: *De la vie et de la mort*, dépose maintenant son rapport final intitulé: *Des soins de fin de vie de qualité: Chaque Canadien et Canadienne y a droit*.

Respectueusement soumis,

Le président,

MICHAEL KIRBY

Chair

EVIDENCE

OTTAWA, Wednesday, June 7, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 3:33 p.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Today's witnesses are from the Department of Finance. They are here to help us understand the Canada Health and Social Transfer Tax (CHST). They will explain why the federal government really does not know how much money it is contributing to the health care system.

Mr. Bissonnette and Ms Anderson, as you may know, Mr. Lalonde discussed with us the origins of the EPF. If you have not seen his testimony, it concerned the nature of the political bargain that was struck, and why it was struck. The other big change in funding, of course, has been the CHST. It is our hope that you will take a few minutes to ensure that we understand three things: What is the policy rationale? How is it calculated? And, third, since the concern of this committee is the state of the health care system in Canada, we would like you to address why the government does not know the amount of its investment in that system.

I believe that senior federal spokespersons, including possibly even the minister, have indicated that, as a result of the pooling of a lump amount of money, it is difficult to determine precisely how much money the federal government is contributing to health care. Our committee would like know whether that is a factual statement: and, if so, we would like to understand a little bit of the policy rationale for that.

Mr. Bissonnette, would you please proceed.

Mr. Guillaume Bissonnette, General Director, Federal-Provincial Relations and Social Policy Branch, Department of Finance Canada: Mr. Chairman, I do have some brief opening remarks. I have left with the clerk of the committee a reference piece on the history of the CHST.

The federal government provides support to provincial and territorial governments, primarily through three major big programs: the CHST, which we will be discussing, equalization, and territorial formula financing.

The CHST, which supports health, post-secondary education, social services and social assistance, amounts to about \$31 billion per year. Its creation was announced in the 1995 budget, when the government indicated that it would create a new block fund transfer to support provincial health, post-secondary education, and social assistance services. The CHST, because it is a social transfer, requires that the provinces comply with the Canada Health Act and that they not impose residency requirements for social assistance programs.

TÉMOIGNAGES

OTTAWA, le mercredi 7 juin 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 15 h 33 pour examiner l'état du système de santé au Canada.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Nous accueillons aujourd'hui des représentants du ministère des Finances. Ils sont là pour nous aider à comprendre le Transfert canadien en matière de santé et de programmes sociaux (TCSPS). Ils expliqueront pourquoi le gouvernement fédéral ne connaît pas le montant exact de sa contribution au système de santé.

Monsieur Bissonnette et madame Anderson, M. Lalonde a discuté avec nous des origines du FPE. Au cas où vous n'auriez pas lu son témoignage, je vous signale qu'il portait sur la nature du marché politique qui a été conclu et sur les raisons pour lesquelles il a été conclu. L'autre changement important en matière de financement est, bien entendu, le TCSPS. Nous espérons que vous consacrez quelques minutes à nous expliquer la raison d'être de cette politique et comment le transfert est calculé. En troisième lieu, étant donné que l'objet de notre attention est l'état du système de santé au Canada, nous voudrions que vous expliquiez pourquoi le gouvernement ignore le montant de son investissement dans ce système.

Je crois que les hauts fonctionnaires fédéraux, peut-être même le ministre, ont indiqué que, du fait qu'il s'agit d'un montant forfaitaire, il est difficile de déterminer avec précision le montant que le gouvernement fédéral investit dans le système de santé. Nous voudrions savoir si c'est exact et dans ce cas, nous voudrions savoir pour quelles raisons.

Allez-y, monsieur Bissonnette.

M. Guillaume Bissonnette, directeur général, Direction des relations fédérales-provinciales et de la politique sociale, ministère des Finances: Monsieur le président, j'ai quelques observations préliminaires à faire. J'ai remis à la greffière un document de référence qui retrace l'historique du TCSPS.

Le gouvernement fédéral apporte l'essentiel de son aide aux gouvernements provinciaux et territoriaux au moyen de trois grands programmes: le TCSPS, dont nous allons discuter, le Programme de péréquation et la Formule de financement des territoires.

Le TCSPS contribue au financement des soins de santé, de l'enseignement postsecondaire, ainsi que de l'aide sociale et des services sociaux pour environ 31 milliards de dollars par an. Sa création a été annoncée dans le budget de 1995. En effet, le gouvernement y annonçait la création d'un mécanisme de financement global pour contribuer au financement des systèmes provinciaux de soins de santé, d'enseignement postsecondaire, d'aide sociale et de services sociaux. Étant donné qu'il s'agit d'un transfert social, le TCSPS exige des provinces qu'elles se conforment à la Loi canadienne sur la santé et leur interdit

The CHST came into effect on April 1, 1996, giving provinces more flexibility to design and administer social programs and to allocate funds amongst social programs according to their own priorities.

It is important to understand that the CHST replaced two existing programs. It replaced the Canada Assistance Plan, a cost-shared transfer, which helped fund provincial social assistance and social service programs. The CHST also replaced Established Programs Financing, a block-funded transfer, which helped fund health care and post-secondary education.

The structure of the CHST is not unlike its EPF predecessor, because it is provided through both cash and tax transfers.

What is a tax transfer? That occurs when the federal government agrees to reduce its personal and corporate income tax rates, while allowing provinces, at the same time, in a synchronized way, to raise their tax rates by the same amount. For taxpayers, there is no difference in the total tax take. For governments, however, there is a big difference. Revenue that normally would have flowed to the federal government begins to flow, instead, directly to provincial and territorial governments.

There was a major tax transfer in 1977, with the creation of the EPF. That tax transfer was, in fact, carried over into the CHST. Provinces and territorial governments continue to benefit from the transfer. Its value has grown from its initial level of \$2.7 billion in 1977 to over \$15 billion today.

As we look at the CHST today, much like in 1977, in the last days of the EPF, it is still the case that about one half of the CHST takes the form of cash while the other half takes the form of tax transfers.

In its 1996 budget, the federal government decided to establish an \$11 billion floor below the cash of the CHST to make sure that the growth of tax points would not erode the value of the cash. In 1998, with a balanced budget in sight, the federal government acted again to increase the CHST, increasing the cash floor to \$12.5 billion.

[Translation]

The 1999 fiscal conditions allowed the federal government to make an even larger investment in health care, by increasing CHST payments to provinces and territories by \$11.5 billion over five years.

Of this amount, which was entirely directed at health care, \$8 billion was provided through future-year increases in the recurrent CHST, and \$3.5 billion was provided as a one-time supplement to the CHST from funds available in 1998-99.

d'imposer une période minimale de résidence comme facteur d'admissibilité à leurs programmes d'aide sociale.

Le TCSPS est entré en vigueur le 1er avril 1996 et a conféré aux provinces et aux territoires une latitude accrue pour concevoir et administrer leurs programmes sociaux, et pour répartir leurs paiements entre ces programmes, conformément à leurs priorités.

Il est important de comprendre que le TCSPS a remplacé deux programmes. Il a remplacé le Régime d'assistance publique du Canada, un programme de transfert à frais partagés qui aidait à financer les programmes provinciaux d'aide sociale et de services sociaux. Il a également remplacé le Financement des programmes établis, un mécanisme de financement global qui contribuait à financer les soins de santé et l'enseignement postsecondaire.

Le TCSPS a des points communs avec le FPE, puisqu'il procède sous forme de versements en espèces et de transferts de points d'impôt.

Qu'est-ce qu'un transfert de points d'impôt? Il y a transfert de points d'impôt quand le gouvernement fédéral accepte de réduire ses taux d'imposition sur les particuliers et les sociétés pour permettre aux provinces et aux territoires de majorer parallèlement d'autant les leurs. Le total des impôts à payer est rigoureusement le même pour les contribuables. Par contre, pour les gouvernements, il y a une grosse différence. Des recettes qui auraient dû normalement alimenter les coffres du fédéral commencent à être versées directement dans ceux des provinces et des territoires.

Nous avons assisté à un important transfert de points d'impôt en 1977 avec la création du FPE. Ce transfert de points d'impôt a été en fait reconduit avec le TCSPS. Les gouvernements des provinces et des territoires continuent donc à bénéficier de ce transfert. Son montant est passé de 2,7 milliards de dollars en 1977 à plus de 15 milliards de dollars aujourd'hui.

Aujourd'hui comme en 1977, durant les derniers jours du FPE, les transferts du TCSPS se répartissent également entre les versements en espèces et les transferts de points d'impôt.

Dans son budget de 1996, le gouvernement fédéral a décidé d'intégrer au TCSPS un *plancher en espèces+ de 11 milliards de dollars pour s'assurer que la croissance du montant des transferts de points d'impôt ne puisse affaiblir la valeur des versements en espèces. En 1998, alors qu'un budget équilibré était à portée de la main, le gouvernement fédéral a porté la composante en espèces du TCSPS à 12,5 milliards de dollars.

[Français]

La situation budgétaire de 1999 a permis au gouvernement fédéral d'investir encore plus en soins de santé en augmentant les versements du TCSPS aux provinces et aux territoires de 11,5 milliards de dollars sur cinq ans.

De ce montant, consacré en totalité aux soins de santé, 8 milliards de dollars correspondaient à des augmentations du transfert canadien récurrent durant les années à venir et 3,5 milliards de dollars correspondaient à un supplément ponctuel, versé au titre du transfert canadien à partir des liquidités disponibles durant l'exercice 1998-1999.

Provinces were left free to draw down this supplement according to their needs and to the time profile of their needs, to best meet the needs of their health systems.

Assuming an orderly drawdown over the next three years means that total support for health care will increase by \$2 billion in 1999-2000, and by \$2.5 billion in each of the following three years.

The disparities in the way the CHST was allocated across provinces, at the time of the 1999 budget — just before this budget — would have been reduced by half by 2002-03. The 1999 budget legislation provides for the complete elimination of these disparities per capita in the allocation of this transfer by 2001-02., thus by next year. Next year, all provinces will receive identical per capita CHST entitlements, providing equal support for health and other social services to all Canadians.

We are coming to the last chapter of our history, the 2000 federal budget. The 2000 budget put another \$2.5 billion in the Canadian transfer. Of course, these funds will be available to provinces when Bill C-32 receives Royal Assent. I think it is presently under consideration in the Senate.

[English]

Once again, the provinces and territories will have complete flexibility in deciding how and when to draw on this lump sum amount of \$2.5 billion. They can choose to spend it now or to spread it over the course of four years, as they see fit. If you look retroactively, to the beginning of our story, this constitutes the fourth consecutive federal enhancement of the CHST. This latest enrichment will add about \$1 billion in 2001 and \$500 million in each of the following years.

What does this mean overall? It means that CHST cash, in total, will reach \$15.5 billion this year — which is about 25 per cent more than in 1998-99. This year, total CHST entitlements, when you add the cash plus the tax, will exceed their previous peak. If you look only at the cash component of the CHST, then it will have been fully restored next year. If you combine the cash plus tax, look at the whole of the CHST, it will reach an all-time high of \$31 billion this year.

That concludes my opening remarks. I wanted to keep them brief, given that a reference piece has been provided. We would be pleased to answer any questions honourable senators might have.

The Chairman: As much for the record as for anything else, I want to take you back through your opening statement and ask you several clarification questions.

Les provinces avaient toute latitude pour décider quand encaisser ce supplément selon leurs besoins et selon le profil temporel de leurs besoins de façon à répondre le mieux possible aux besoins de leurs systèmes de santé.

Si on fait l'hypothèse que les provinces étalent l'utilisation de ce supplément sur les trois ans à venir, cela augmente l'aide totale pour les soins de santé de 2 milliards de dollars en 1999-2000, et de 2,5 milliards au cours des trois années subséquentes.

Les disparités dans la façon dont le transfert canadien était réparti entre les provinces, lors du budget de 1999 — juste avant ce budget — auraient été réduites de moitié d'ici 2002-2003. Le budget de 1999, lui, éliminera complètement ces disparités per capita dans la répartition dans ce transfert d'ici 2001-2002, donc d'ici l'an prochain. L'an prochain toutes les provinces recevront des droits par l'entremise du transfert canadien qui seront identiques par habitant de façon à ce qu'elles bénéficient de la même aide par habitant dans le domaine de la santé et des autres services sociaux.

Le dernier chapitre de notre histoire, le budget fédéral de l'an 2000. Le budget de l'an 2000 a injecté un autre 2,5 milliards de dollars dans le transfert canadien. Les provinces, évidemment, disposeront de ces fonds une fois que le projet de loi C-32 aura reçu la sanction royale. Je crois qu'il fait l'objet d'une étude par le Sénat présentement.

[Traduction]

Les provinces et les territoires disposeront de toute latitude de choisir comment et quand utiliser ce montant global de 2,5 milliards de dollars. Elles pourront y faire appel immédiatement ou à n'importe quel moment pendant cette période de quatre ans, selon leurs besoins. Si l'on remonte en arrière, au début de notre histoire, c'est la quatrième amélioration fédérale consécutive apportée au TCSPS. Cette dernière amélioration injectera environ un milliard de dollars en plus en 2001 et 500 millions de dollars pour chacune des trois années suivantes.

Qu'est-ce que ça représente au total? Ça représente en tout des transferts en espèces de 15,5 milliards de dollars cette année — soit près de 25 p. 100 de plus qu'en 1998-1999. Cette année, le total des droits au TCSPS, quand on additionne les versements en espèces et les transferts de points d'impôt, dépassera le sommet précédent. L'an prochain, le total des transferts en espèces du TCSPS sera ramené à son plein montant. Le total des versements en espèces et des transferts de points d'impôt du TCSPS atteindra le record absolu de 31 milliards de dollars cette année.

C'est tout ce que je voulais dire en guise d'introduction. Je voulais rester bref, étant donné que je vous ai remis un document de référence. C'est avec plaisir que nous répondrons à vos questions.

Le président: Aussi bien pour que ce soit consigné au compte rendu que pour d'autres raisons, je vous poserai quelques questions sur vos observations préliminaires pour obtenir des éclaircissements.

At the bottom of page 3, you say that the CHST is provided through a cash transfer and a tax transfer like the EPF. At the time of the CHST, were there additional tax transfer points, or were the tax transfer points that you are referring to on the bottom of page 3 those that we transferred in 1977 with the EPF?

Mr. Bissonnette: They are exactly the same points. They were carried over.

The Chairman: My point is that, in effect, there was a longstanding history of tax transfer points and that, therefore, the CHST represented a cash "lumping together." What really happened is that the amount of money changed but that change was only in cash, not in tax points; correct?

Mr. Bissonnette: To make sure that we are all clear, EPF was a program that involved both tax points and cash. The tax points that were in the EPF component were simply renamed and put into a larger "house" called the CHST.

The Chairman: That is right. On the bottom of page 4, you refer to the cash floor concept. I want to make sure that I understand this correctly. In the cash floor, first, the CHST formula is calculated; second, the value of the tax points is calculated; and third, the difference between the two is calculated, and that would normally be in cash. What you are doing is making sure that if that difference was, for instance, only \$9 billion, you would nevertheless make it \$11 billion; correct? In effect, that increases the total value of the CHST; correct?

Mr. Bissonnette: You are quite right. That was a time when the cash was computed as a residual — as the difference between total entitlement and the value of tax transfer points.

The Chairman: That is the way it was done since the beginning of the EPF.

Mr. Bissonnette: Correct.

The Chairman: Therefore, in terms of the cash floor, if the residual is less than the cash floor the federal government will give the provinces more money — because the feds will always pay the cash floor.

Mr. Bissonnette: That is right. We will override the calculation with the cash floor.

The Chairman: I had some trouble with your mathematics, in terms of the 1999 federal budget. Let's deal with the \$11.5 billion — the \$3.5 billion upfront and then \$8 billion over time.

The \$11.5 billion was calculated, according to your brief, in the following way: \$2 billion in each of two years, which equals \$4 billion, and then \$2.5 billion in each of the following three years. Hence, the \$11.5 billion does not include the \$3.5 billion initial one-time shot. Am I correct?

Mr. Bissonnette: Yes, it does. The best way to answer your question — and tell me if this is a legitimate suggestion — would

Vers le milieu de la page 4, vous dites que le TCSPS procède sous forme de versements en espèces et de transferts de points d'impôt, comme le FPE. À l'époque du TCSPS, y avait-il des points de transfert d'impôt supplémentaires ou ceux que vous mentionnez vers le milieu de la page 4 ont-ils été transférés en 1977 avec le FPE?

M. Bissonnette: Ce sont exactement les mêmes points. Ils ont été transférés.

Le président: Ce que je veux dire, c'est qu'en fait, les transferts de points d'impôt sont une vieille tradition et que, par conséquent, le TCSPS ne représente qu'un transfert global. En fait, le montant d'argent a changé mais le changement provient uniquement des versements en espèces et pas des points d'impôt. Est-ce bien cela?

M. Bissonnette: Pour être sûr que tout soit clair, le FPE était un programme comprenant à la fois des points d'impôt et des versements en espèces. Les points d'impôt du FPE ont simplement été rebaptisés et transférés dans un programme de plus grande envergure appelé le TCSPS.

Le président: C'est exact. Vers le bas de la page 5, vous parlez d'un «plancher en espèces». Je voudrais m'assurer que je comprends bien cette notion. On calcule d'abord la formule du TCSPS, puis la valeur des points d'impôt. Enfin, on calcule la différence entre les deux et cette différence est normalement en espèces. Par exemple, si la différence n'était que de 9 milliards de dollars, le plancher serait de toute façon de 11 milliards. Est-ce bien cela? En fait, ce plancher augmente la valeur totale du TCSPS. Est-ce bien cela?

M. Bissonnette: C'est tout à fait exact. À une certaine époque, le montant en espèces correspondait à la différence entre le montant total des droits et la valeur des transferts de points d'impôt.

Le président: C'est ainsi que l'on procédait depuis la création du FPE.

M. Bissonnette: Exactement.

Le président: Par conséquent, en ce qui concerne le plancher en espèces, si la différence est inférieure à ce plancher, le gouvernement fédéral donnera davantage d'argent aux provinces parce qu'il payera toujours selon ce plancher.

M. Bissonnette: C'est exact. Nous payons toujours l'équivalent du «plancher en espèces».

Le président: J'ai quelque difficulté à comprendre vos calculs en ce qui concerne le budget fédéral de 1999. Parlons des 11,5 milliards de dollars — les 3,5 milliards de dollars initiaux et les 8 milliards de dollars étalés sur plusieurs années.

D'après votre mémoire, la somme de 11,5 milliards de dollars a été obtenue comme suit: 2 milliards de dollars par année pendant deux ans, ce qui fait 4 milliards de dollars, puis 2,5 milliards de dollars par année pour les trois années suivantes. Par conséquent, cette somme ne comprend pas le versement initial de 3,5 milliards de dollars. Est-ce bien cela?

M. Bissonnette: Si, elle le comprend. La façon la plus simple de répondre à votre question — et je vous demande de me dire si

be to turn to a table in the paper that we have handed out. Is that possible? It is at page 8.

The Chairman: The top paragraph on page 6 is equivalent to the second line on the table to which you refer.

Mr. Bissonnette: Yes.

The Chairman: The \$3.5 billion in 1988-89 is not included when you talk about the \$11.5 billion over five years. It is in addition to that; correct?

Ms Barbara Anderson, Director, Federal-Provincial Relations Division, Department of Finance Canada: Mr. Chairman, it is included. When we put that \$3.5 billion into a trust fund, we nominally allocated it over the three years. In the second bracket, it is indicated how the \$3.5 billion is broken down.

The Chairman: The \$3.5 billion is buried in the three figures of \$2 billion, \$1 billion and \$0.5 billion.

Ms Anderson: Correct.

Mr. Bissonnette: The third and fourth line of that table provides a decomposition of the \$11.5 billion into its two components, the \$3.5 billion and the \$8 billion. It is the two lines in italics on that table.

The Chairman: Let us discuss the issue that really intrigues me.

In the budget, it was indicated that this was designed to meet health care needs. Since you grant the money as a lump sum — which, by the way, you did last year, as well, and then you talked about all the money that you are putting into health. Since the money is granted in a lump sum, how do you know it is being spent on health?

Mr. Bissonnette: Obviously, money is fungible.

The federal government contributes to each province in respect of health care, post-secondary education and social assistance through this transfer. We know, for instance, that provinces spend more than we do on health care. Obviously, one cannot actually trace dollars, but if a province actually spends a lot more, and they do, than we contribute, then I think there is a certain assurance that it is being spent on health care.

The Chairman: What you are really saying is that you claim it is spent on health care simply on the grounds that the money that that goes to the provinces that you say is spent on health care is less than the amount the provinces spent on health care, therefore it is spent on health care.

Let me go back to the early days of EPE. In the mid 1980s, it was fairly easy to establish that several provinces, particularly in the area of the country where Senator Robertson and I come from, could be shown to be spending essentially nothing on

c'est bien le cas — consiste à examiner un tableau qui se trouve dans le document de référence que nous vous avons remis. Est-ce possible? Ce tableau se trouve à la page 9.

Le président: Le premier paragraphe de la page 7 du mémoire correspond à la deuxième ligne de ce tableau.

M. Bissonnette: Oui.

Le président: Les 3,5 milliards de dollars versés en 1988-1989 ne sont pas inclus dans les 11,5 milliards de dollars répartis sur cinq ans. Cette somme initiale vient s'y ajouter. Est-ce bien ça?

Mme Barbara Anderson, directrice, Division des relations fédérales-provinciales, ministère des Finances: Cette somme est incluse. Quand nous avons placé ces 3,5 milliards de dollars dans un fonds de fiducie, nous les avons répartis nominalement sur les trois années. La ventilation de cette somme est indiquée à la deuxième ligne en retrait.

Le président: C'est la somme des trois chiffres qui sont indiqués, 2 milliards de dollars, 1 milliard de dollar et 0,5 milliard de dollars.

Mme Anderson: C'est exact.

M. Bissonnette: Les troisième et quatrième lignes de ce tableau indiquent la répartition de ces 11,5 milliards de dollars en deux sommes, les 3,5 milliards de dollars et les 8 milliards de dollars. Ce sont les deux lignes en italiques.

Le président: Je voudrais que nous en discutons parce que cette question m'intrigue.

Il était spécifié dans le budget que cette somme devait couvrir les besoins en matière de soins de santé. Or, étant donné que vous accordez l'argent sous forme de transfert global, comment savez-vous si ces fonds sont bien consacrés à la santé? L'année dernière, vous vous êtes vantés des fonds considérables que vous investissiez dans la santé. Comment pouvez-vous être sûrs que ces fonds sont bien consacrés à la santé étant donné qu'ils sont versés en bloc?

M. Bissonnette: Ces fonds sont, bien entendu, fungibles.

Par le biais de ce transfert, le gouvernement fédéral verse à chaque province une contribution pour les soins de santé, l'enseignement postsecondaire et l'assistance sociale. Nous savons par exemple que les provinces dépensent plus que le fédéral dans le secteur des soins de santé. Bien entendu, on ne peut suivre à la trace chacune de ces dépenses mais, si une province dépense beaucoup plus que ce que nous lui versons, et c'est le cas, j'estime que c'est en quelque sorte une garantie que notre argent est effectivement dépensé dans le secteur des soins de santé.

Le président: En fait, vous concluez que ces fonds sont bien dépensés dans le secteur des soins de santé du seul fait que votre contribution est inférieure au total des dépenses des provinces dans ce secteur.

Je voudrais parler de l'époque qui a directement suivi la création du FPE. Au milieu des années 80, il était assez facile de prouver que plusieurs provinces, surtout celle dont le sénateur Robertson et moi sommes originaires, ne faisaient pratiquement

post-secondary education, because the federal government had an arbitrary way of dividing how much was being spent on post-secondary education and how much was being spent on health. When you looked at the amount that some of the smaller provinces were actually spending on post-secondary education, in at least one case that I recall it was less than the total amount the feds claimed they were giving them for post-secondary education. That may have been true out West, also.

Clearly, the federal government argument in those days was fallacious, right? I will say "right"; the record can show that you did not comment.

It seems to me that there is a huge degree of fictitiousness here, in the sense that we are saying that we are giving you money for health care but we have no way of really knowing that the money will be spent on health care. If we give a province \$10 billion and we see that the province is spending \$15 billion on health care, we pretend that \$10 billion is federal money and \$5 billion is provincial. The reality is that there is no way of knowing.

Let me put it another way. If we increased the money we give to each province, and claimed that we were doing so to increase spending on health care, there is no way that we could guarantee that that would happen. Once we give them the money, to use your finance term, it is fungible; the money can be spent on anything. We just do not have any control; correct?

Mr. Bissonnette: Let me come at this in several ways.

The Chairman: I assume that the answer to my question is yes, but I would be happy to hear your several ways of describing it.

Mr. Bissonnette: Let me come at this in several ways. First, all provinces, over the past three or four years, have been significantly reinvesting in their health care systems. After a period of deep restraint, of a plateau, they are all now reinvesting quite vigorously.

Second, we did receive, at the time of the 1999 budget, and in fact it was referred to in the legislation that authorizes the CHST increase, a commitment from all premiers, by signed letter, that this increase would be devoted to health care.

The Chairman: Why would they not do that? If we did not give them anything, their rate of increase of health care expenditures would have to be bigger than what we were giving them anyway. Anyone who would not sign that letter would be crazy.

How do we guarantee that the money is over and above what they would have spent otherwise? That is really my issue. Are we just allowing our money to substitute for money the provinces would have spent anyway?

aucune dépense dans le secteur de l'enseignement postsecondaire. À cette époque, le gouvernement répartissait de façon arbitraire le montant des dépenses entre l'enseignement postsecondaire et le secteur de la santé. Dans plusieurs petites provinces, et dans au moins une à ma connaissance, les dépenses dans l'enseignement postsecondaire étaient cependant inférieures au montant que le gouvernement fédéral prétendait accorder à ce titre. C'était peut-être le cas dans l'Ouest également.

À cette époque, l'argument du gouvernement fédéral était fallacieux. Est-ce exact? Je dirais que c'est «exact». Le compte rendu indiquera que vous n'avez pas fait de commentaires.

J'ai l'impression que l'on fait toutes sortes de suppositions qui relèvent de la pure fiction. En effet, nous transférons des fonds pour les soins de santé sans toutefois avoir la possibilité de vérifier s'ils sont effectivement consacrés à ce secteur. Nous supposons que si une province a dépensé 15 milliards de dollars dans ce secteur alors que nous ne lui en avons donné que 10, ça représente 10 milliards de dollars de fonds fédéraux et 5 milliards de dollars de fonds provinciaux. En fait, nous n'avons aucun moyen d'en être sûrs.

Permettez-moi de vous expliquer mon raisonnement d'une autre façon. Si nous augmentions le montant que nous accordons à chaque province pour accroître les dépenses dans le secteur des soins de santé, nous n'aurions aucun moyen de nous assurer de sa destination réelle. Quand nous transférons ces fonds aux provinces, ils sont fungibles, pour employer le même terme financier que vous. Ces fonds peuvent être dépensés de n'importe quelle façon. Nous n'avons absolument aucun contrôle. Est-ce bien cela?

M. Bissonnette: J'aurais plusieurs points à signaler à ce propos.

Le président: Je suppose que la réponse à ma question est affirmative mais j'écouterai bien volontiers ce que vous avez à dire.

M. Bissonnette: J'aurais donc plusieurs points à signaler. Le premier est que toutes les provinces ont réinvesti beaucoup dans leur système de soins de santé au cours des trois ou quatre dernières années. Après une période de fortes restrictions et de stagnation, elles réinvestissent toutes beaucoup dans ce secteur.

Le deuxième point est que, au moment où nous avons préparé le budget de 1999, et c'était spécifié dans le projet de loi autorisant l'augmentation du TCSPS, tous les premiers ministres des provinces se sont engagés, dans une lettre dûment signée, à consacrer cette augmentation aux soins de santé.

Le président: Pourquoi pas? Si nous ne leur donnions rien, le taux d'accroissement des dépenses consacrées aux soins de santé serait encore supérieur à ce que nous leur donnons. Il faudrait être fou pour refuser de signer une telle lettre.

Comment peut-on garantir que ce montant vient effectivement s'ajouter à celui qu'elles auraient dépensé de toute façon si elles n'avaient pas obtenu cette augmentation? C'est là où je veux en venir. Est-ce que les fonds supplémentaires que nous octroyons

Mr. Bissonnette: I am not sure that one can answer that question, Mr. Chairman, because it means measuring something that is observable and comparing it to a non-observable, what provinces would have otherwise done.

I think there has been an evolution in the notion of accountability. There has been a long, steady evolution away from tracing dollars and tracing inputs to broader, more modern definitions of accountability that have to do with measuring results.

One could look back at the history of these transfers, since the Second World War. In fact, there has been a constant search for an accountability link with the dollars being spent. If one looks at that evolution, one sees that, in the 1940s, we started with accountability, meaning that the federal government would actually inspect provincial hospitals to find out whether they met certain standards.

In the 1950s, we moved to a slightly more flexible form of accountability, that is, cost-sharing, where we agreed that we would cost-share a certain well-defined basket of doctor services and hospital services.

With the advent of EPF, we moved, yet again, to another notion of accountability, which was less concerned with the use of inputs and the matching of inputs. It was a form of accountability that basically gave a block fund, had some general principles, and then counted upon the provinces to use the money in a way that respected those general principles.

If we carry the evolution of this practice of accountability right up to the social union framework agreement, we are now seeing accountability being defined much more in terms of results achieved and in terms of outcomes.

In a sense, there has been a shift away from inputs to outputs to broader results. There has been a shift, as well, in the doctrine of accountability and what we mean by accountability.

The Chairman: I would love to debate that with you, but I will come back to it at the end.

Senator Robertson: I will return to your point, Mr. Chairman, about budgets and where the money is going. There is a lot of transparency in the provinces; we only need to look at the health budgets and add it up. The health budgets are easily identified, but I will not belabour that. I want to begin on a different note.

The provinces, in particular, are interested in stable funding. This has been one of their major concerns over the years. On what principles do you base the distribution of expenditures for the funding of health care between the two orders of government? As you know, the provinces have already proposed nine basic principles to establish greater stability. What would be your principles to help in that regard?

Mr. Bissonnette: I would say that we are trying to balance a number of competing notions. We obviously want to take into account the notion of affordability, which is important. We also

remplacent les sommes que les provinces auraient dépensées de toute façon?

M. Bissonnette: Je ne suis pas certain de pouvoir répondre à cette question, monsieur le président. Pour cela, il faudrait établir une comparaison purement fictive pour savoir ce que les provinces auraient fait dans d'autres circonstances.

Je pense que la notion de responsabilité financière a évolué. Alors qu'autrefois on essayait de retrouver la trace de la moindre dépense, on a progressivement opté pour une conception plus moderne de la responsabilité financière fondée sur l'évaluation des résultats.

On pourrait retracer l'histoire de ces transferts depuis la Seconde Guerre mondiale. En fait, on n'a jamais cessé d'essayer d'exiger des preuves de dépenses. Quand on suit l'évolution de la notion de responsabilité financière, on constate que, dans les années 40, le gouvernement fédéral faisait littéralement des inspections dans les hôpitaux provinciaux pour vérifier s'ils étaient conformes à des normes précises.

Dans les années 50, on a adopté une formule un peu plus souple, celle du partage des coûts, en vertu de laquelle nous avons convenu de partager les coûts en ce qui concerne un panier bien précis de services médicaux et hospitaliers.

Avec la création du FPE, nous avons modifié, une fois de plus, la notion de responsabilité financière qui cessait dès lors d'être fondée rigoureusement sur l'utilisation des intrants et leur comparaison. Cette nouvelle forme de responsabilité financière, fondée essentiellement sur un transfert global, s'appuyait sur quelques principes généraux; pour le reste, on comptait sur les provinces.

Depuis l'adoption du contrat social cadre, notre conception de la responsabilité financière est nettement plus axée sur les résultats que sur une justification rigoureuse des dépenses.

D'une certaine façon, on s'intéresse davantage aux extrants qu'aux intrants et notre conception de la responsabilité financière a complètement changé.

Le président: J'aimerais beaucoup en discuter avec vous mais j'y reviendrai à la fin de la séance.

Le sénateur Robertson: Monsieur le président, je reviens à la question des budgets et de la destination finale des fonds que vous avez abordée. La transparence est grande dans les provinces; il suffit d'examiner les budgets de la santé et de faire le calcul. Les budgets de la santé sont faciles à identifier mais je n'insisterai pas trop sur la question. Je voudrais commencer sur un ton différent.

Ce qui intéresse surtout les provinces, c'est un financement stable; c'est une de leurs préoccupations majeures. Sur quels principes fondez-vous la répartition des dépenses en matière de financement des soins de santé entre les deux paliers de gouvernement? Les provinces ont déjà proposé neuf principes de base pour accroître la stabilité. Quels principes proposeriez-vous à cette fin?

M. Bissonnette: Je dirais que nous essayons de concilier plusieurs notions contradictoires. Nous devons bien entendu, tenir compte de l'importante notion d'abordabilité. Nous devons

want to take into account the notion of adequacy — which, in a sense, is the flip side. How much is adequate? As well, we want to take into account a notion that is talked about frequently on the environmental side, but which I think applies here, too, and that is the concept of sustainability over time and the notion of stability.

Of course, there are conflicts between all those pairs of concepts. You cannot make commitments about a stability. They are so strong that when the world changes — and nobody can control what happens in the world — you find that your commitments are no longer sustainable. You do not want to make commitments, for example, about adequacy and then find that those commitments are not affordable — not just by one order of government but by both orders of government.

Thus, in a sense, we are trying to balance all of these notions. Presumably, we are also trying to balance the fact that there are other spending priorities that are also meritorious. Health is important for the future of the country, but so are post-secondary education, research and innovation. They are viewing as key to the development of our country.

I believe that it truly is a balancing act, one that involves judgment.

Senator Robertson: Are the provinces aware of the enunciated principles that you have just identified to me? Do you discuss the principles that you have just identified with the provinces?

Mr. Bissonnette: Ms Anderson chairs many of those meetings.

Ms Anderson: Yes, we do discuss the principles quite frequently.

Senator Robertson: That is good.

Ms Anderson: There is widespread agreement among officials that are involved in fiscal arrangements in Canada as to the principles. We have a very specific list to which we keep going back. Everyone understands that there is a need to balance between the principles. The tilt of that balance is not as easy to get widespread agreement on. Certainly, there is an agreement on the principles, and there is some agreement on the priority of the principles. However, when you get into balancing, as Mr. Bissonnette said, affordability and adequacy it gets down to making difficult decisions.

Senator Robertson: That is good. That is some progress.

The federal position includes tax points. The provincial position does not include tax points. This is the argument.

If I understand my material well — you can correct me if I am wrong — in 1995-96 all the transfers to the provinces, which included the EPF, the CAP and the equalization payment, accounted for about one quarter of the federal budget programs. If the equalization payment were taken out, you are looking at about 18 per cent.

Let us look at the figures. Between 1994 and 1995, the dollars, just for CAP and EPF, I believe, were \$19.3 billion. Does that sound right?

également tenir compte de la notion qui en est en quelque sorte le corollaire. Combien est suffisant? Nous devons également tenir compte d'une notion dont on parle souvent dans le contexte de l'environnement et qui est également valable dans ce contexte; il s'agit du concept de durabilité dans le temps ou de stabilité.

Ces deux types de concepts sont, bien entendu, contradictoires. On ne peut pas prendre d'engagements en matière de stabilité. Un engagement est très sérieux et, lorsque la situation évolue dans le monde — et personne ne peut contrôler ce qui se passe dans le monde —, on constate qu'il n'est plus possible de le tenir. On ne veut pas prendre d'engagements en ce qui concerne la «suffisance», par exemple, pour constater ensuite qu'on n'a pas les moyens de les respecter; cela est valable pour les deux paliers de gouvernement.

Par conséquent, on essaie en quelque sorte de faire un compromis entre toutes ces notions. Nous essayons également, je présume, de tenir compte du fait que d'autres priorités en matière de dépenses ont tout autant d'importance. La santé est importante pour l'avenir du pays mais l'enseignement secondaire, la recherche et l'innovation aussi. Ils sont essentiels au développement de notre pays.

Je crois que c'est une question de compromis et qu'il faut faire preuve de discernement.

Le sénateur Robertson: Les provinces sont-elles au courant des principes que vous venez de mentionner? Est-ce que vous en avez discuté avec elles?

M. Bissonnette: Mme Anderson préside de nombreuses réunions auxquelles elles participent.

Mme Anderson: Oui, nous discutons assez souvent des principes.

Le sénateur Robertson: C'est bien.

Mme Anderson: La plupart des fonctionnaires qui s'occupent des arrangements fiscaux au Canada approuvent ces principes. Nous avons une liste à laquelle nous nous référons continuellement. Toutes les parties concernées comprennent qu'il est nécessaire d'établir un compromis. Il n'est pas aussi facile de s'entendre sur le résultat de ce compromis. Nous sommes d'accord sur les principes et la priorité des principes. Cependant, quand on essaie, comme l'a dit M. Bissonnette, de faire un compromis entre l'abordabilité et la «suffisance», on est obligé de prendre des décisions courageuses.

Le sénateur Robertson: C'est bien. Il y a du progrès.

La position du gouvernement fédéral inclut des points d'impôt. La position des gouvernements provinciaux n'en inclut pas. C'est à ce niveau que les opinions diffèrent.

Si je comprends bien — et vous pouvez me corriger si je me trompe — en 1995-1996, tous les transferts aux provinces, qui comprenaient le FPE, le RAPC et le paiement de péréquation, représentaient environ un quart des programmes budgétisés. Sans le paiement de péréquation, ils auraient été d'environ 18 p. 100.

Examinons les chiffres. Entre 1994 et 1995, rien que pour le RAPC et le FPE, le montant se chiffrait à 19,3 milliards de dollars, si je ne me trompe. Est-ce bien cela?

Ms Anderson: Yes.

Senator Robertson: In 1999, the CHST was \$12.5 billion. That was a drop of 35 per cent, which is quite a big drop. In contrast, the federal government spending on all the other programs declined by only 7 per cent.

Why would you cut health, which is so important to the Canadian public, by 5 times the rest of the spending. There is a matter of fairness here. Maybe you cannot answer that because you only deal with dollars in health. I find the percentage of the cuts very strange. A reduction of 35 per cent is significant, whereas 7 per cent is not so bad.

I want to ask about the fairness of those figures.

Mr. Bissonnette: I would have to dispute your starting point, which is to exclude the tax points. The tax points are real revenue that we forego and the provinces get. If you were to make your comparison about what the reduction has been in terms of, say, cash plus tax, you would get a much smaller percentage.

In fact, to pursue your line of investigation, we have been pushed by the public debate to try to arrive at, based on history, a health share of the CHST that would be based on the old sharing notions that were embodied in the EPF. If one performs that operation, we find that, in fact, the cash component of the health component of CHST reached a peak in 1993-94 of \$8.2 billion.

This year, because of the enrichments that we have made, that amount is back up to \$8.1 billion. Next year, we will exceed the previous peak of 1993-94.

That is talking cash only for the notional health portion of the CHST.

Senator Robertson: As you know, the provinces do not agree with you on this. I want to come back to these tax points though, because I agree with Madam Bégin, who said last week that tax points were a dead issue, that we must forget about them.

Senator LeBreton: The witness has just said that it is real revenue that the federal government foregoes. There is only one taxpayer. How can Madam Bégin say that tax points are lost and that we should forget about them?

Senator Robertson: Those tax transfers, as you know, have a long history. They started in the Second World War. The provinces gave up their personal and business taxes to the federal government as part of the war effort. However, that was a temporary arrangement.

Senator Banks: Like income tax.

Senator Robertson: Yes. The provinces agreed to the measure, with the understanding that it was temporary and that the seeded tax would return to them at the end of the war. However, those taxes were never returned to them. Hence, the provinces were no further ahead. There were a number of years lost to them where

Mme Anderson: Oui.

Le sénateur Robertson: En 1999, le TCSPS s'élevait à 12,5 milliards de dollars, soit une diminution de 35 p. 100; c'est beaucoup. Par contre, les dépenses fédérales affectées à tous les autres programmes n'ont diminué que de 7 p. 100.

Pourquoi voudrait-on diminuer cinq fois plus les dépenses dans le secteur de la santé, qui est très important pour les Canadiens, que les autres dépenses? C'est une question d'équité. Vous ne pouvez peut-être pas répondre parce que vous vous basez uniquement sur les montants. Je trouve la proportion de la diminution très étonnante. Une réduction de 35 p. 100 est une forte réduction alors qu'une de 7 p. 100 n'est pas trop grave.

Je voudrais savoir si vous trouvez que c'est équitable.

M. Bissonnette: Je conteste votre premier commentaire sur les points d'impôt. Les points d'impôt sont des recettes réelles auxquelles nous renonçons pour les transférer aux provinces. Si vous calculiez la réduction en vous basant sur les versements en espèces et les points d'impôt, le pourcentage serait beaucoup moins élevé.

En fait, pour répondre à votre question, je dirais que nous avons été poussés par la population à en arriver à une proportion du TCSPS pour la santé qui soit fondée sur les vieilles notions de partage qu'incarnait le FPE. Si on fait le calcul, on constate qu'en fait les transferts en espèces de la composante santé du TCSPS ont atteint un sommet de 8,2 milliards de dollars en 1993-1994.

Cette année, grâce aux augmentations que nous avons prévues, les transferts en espèces se chiffrent à 8,1 milliards de dollars. L'année prochaine, le sommet précédent de 1993-1994 sera dépassé.

Il s'agit uniquement des transferts en espèces de la portion «santé» du TCSPS.

Le sénateur Robertson: Les provinces ne sont pas d'accord avec vous sur ce point, et vous le savez. Je voudrais toutefois revenir à la question des points d'impôt parce que je suis d'accord avec Mme Bégin qui a dit la semaine dernière qu'il fallait oublier les points d'impôt puisqu'ils vont disparaître.

Le sénateur LeBreton: Le témoin vient de dire que ce sont des recettes réelles auxquelles le gouvernement fédéral renonce. Il n'y a qu'un seul contribuable. Comment Mme Bégin peut-elle affirmer qu'il faut oublier les points d'impôt sous prétexte qu'ils sont appelés à disparaître?

Le sénateur Robertson: Comme vous le savez, l'origine de ces transferts fiscaux remonte loin dans le temps. Ils ont été établis à l'époque de la Seconde Guerre mondiale. Les provinces ont renoncé à leurs impôts sur les revenus des particuliers et des sociétés au profit du gouvernement fédéral, dans le cadre de l'effort de guerre. Il s'agissait toutefois d'une entente temporaire.

Le sénateur Banks: Comme l'impôt sur le revenu.

Le sénateur Robertson: Oui. Les provinces ont accepté cette mesure, à condition qu'elle soit temporaire et qu'elles récupèrent ces impôts à la fin de la guerre. Cependant, elles ne les ont jamais récupérés. Par conséquent, elles ont pris du retard. Pendant plusieurs années, elles n'ont pu profiter de ces impôts pour

they did not benefit from that tax for their provincial programs. The 1977 transfer back to the provinces was just a catch-up, to what they gave up during the war.

There is a notional link between the CHST and certain tax points shifted by Ottawa to the provinces in the years leading up to and including the creation of the EPF in 1977. It is not an ongoing federal transfer to provinces any more than the provincial tax room shifted under the wartime tax. Agreement constitutes an ongoing provincial transfer.

I believe, honestly, that using these tax points creates a misleading picture of the size of the cuts to the federal health and social transfers. I think it is wrong to use them. I am on the side of the provinces, the side of the gods, with this argument on tax points. It is terribly important that we clear this up.

In 1977, there was no new-found money for the provinces. The provinces struggled after the war. Some of us are old enough to remember all the problems the provinces faced. Provincial treasuries were not flush.

I can remember when I first ran for office. I was standing on a hill in Riverview looking at 42 miles of unpaved streets. There was just no money. You know where I am coming from.

Mr. Bissonnette: Senator, you are covering a lot of interesting historical ground. I do not claim to be an expert on all that history, but the tax rental arrangements that you were referring to during the war were actually quite different from the tax point transfers.

Senator Robertson: I disagree with you, but we will come to that.

Mr. Bissonnette: Let me add one last comment. We understand full well the position of those who do not feel that the tax points are real. It is a position that is adopted by many people. The puzzle for us, though, is that if the tax points are not real how is it that several provinces are asking us for more of them? If they do not count, why are they asking for more? That is the puzzle.

Senator Robertson: The puzzle could reasonably be solved, I would suggest, because we have now balanced the act. If you are not going to give them any more money give them more tax points, to make up for money that they require.

We have spent much time on this argument, but I know the provinces feel very strongly about it. I feel very strongly about it, as you can tell. I come back again to what Madam Bégin said. We are beating our heads against a stone wall with this argument.

I may come back to this subject at a future time.

Ms Anderson: I am not disputing the honourable senator's interpretation of the two sides of it. It is important to remember that the provinces do accept fundamentally the way that we allocate the CHST. It is based on the acceptance of the tax points and what they are worth in different provinces.

financer leurs programmes. Le transfert consenti aux provinces en 1977 n'était en fait que la récupération des impôts auxquels elles avaient renoncé pendant la guerre.

Il existe un lien entre le TCSPS et certains points d'impôt transférés aux provinces par le gouvernement fédéral dans les années qui ont précédé la création du FPE, en 1977. Les provinces n'ont fait que récupérer l'espace fiscal auquel elles avaient renoncé dans le cadre de l'effort de guerre. L'entente constitue un transfert provincial permanent.

Je suis sincèrement convaincue que le fait d'utiliser des points d'impôt donne une fausse impression de l'importance des coupures dans les transferts fédéraux en matière de santé et d'aide sociale. J'estime que ce n'est pas honnête. Je prends parti pour les provinces en ce qui concerne les points d'impôt. Il est terriblement important pour moi d'éclaircir cette question.

En 1977, les provinces n'ont en fait pas reçu d'argent supplémentaire. Elles ont eu de la difficulté après la guerre. Certains d'entre nous sont assez vieux pour se souvenir de tous les problèmes qu'elles ont connus. Leurs moyens financiers étaient plutôt maigres.

La première fois que j'ai participé aux élections, je me trouvais sur une colline à Riverview d'où je pouvais voir 42 milles de rues non asphaltées. On n'avait pas l'argent nécessaire. Vous savez d'où je viens.

M. Bissonnette: Vous citez beaucoup de faits historiques intéressants. Je ne me considère pas comme un expert en la matière mais les accords sur la location de domaines fiscaux auxquels vous faites allusion étaient en fait très différents des transferts de points d'impôt.

Le sénateur Robertson: Je ne suis pas d'accord, mais nous en reparlerons.

M. Bissonnette: Je voudrais faire un dernier commentaire. Nous comprenons très bien la position de ceux et celles qui estiment que les points d'impôt ne sont pas réels. C'est l'opinion de bien des gens. Cependant, si les points d'impôt n'étaient pas réels, pourquoi plusieurs provinces nous en réclameraient-elles davantage? Pourquoi en demanderaient-elles davantage si ça ne comptait pas? N'est-ce pas intrigant?

Le sénateur Robertson: L'énigme pourrait être raisonnablement résolue puisque nous avons maintenant trouvé un bon compromis. Si vous ne voulez pas donner plus d'argent aux provinces, il faut leur donner des points d'impôt supplémentaires pour compenser les sommes dont elles ont besoin.

Nous consacrons beaucoup de temps à en discuter, mais je sais que les provinces y accordent beaucoup d'importance. J'y accorde moi-même beaucoup d'importance, comme vous pouvez le constater. J'en reviens au commentaire qu'a fait Mme Bégin. Nous nous frappons à un mur avec cet argument.

Je reviendrai peut-être à cette question plus tard.

Mme Anderson: Je ne conteste pas l'interprétation des deux aspects de la question que fait l'honorable sénateur. Il ne faut pas oublier que les provinces approuvent la façon dont nous attribuons le TCSPS. Le système est basé sur l'acceptation des points d'impôt et leur valeur dans la province concernée.

I would make a distinction between their acceptance of the concept of how much the federal government transfers and their acceptance of the concept of tax points. It could be both sides trying to arrive at an advantageous number.

I sat on the other side of the table in 1977. I remember just how desperately important it was to provinces to have those tax points. I maintain that they still do accept them as fundamental to the allocation of the program.

The Chairman: I would guess that you were with a "have province" in 1977, because some of us around this table, at least Senator Robertson and myself, were not. We also understood the huge weakness of tax points. Were you from B.C., Alberta or Ontario at the time?

Ms Anderson: I am sure that that is not a question I have to answer.

The Chairman: I can tell you that if you were from anywhere else your position would be different.

Senator Robertson: Yes, in 1977 the provinces were happy that those tax points were returned to them, for obvious reasons. There was a huge grab during the war, but they did not mind giving it up then. I do not know how solidly they are in favour of additional tax points. I am reading a document from the provincial premiers and territorial finance ministers that does not give a happy picture as they look to the future with any more tax points. They are looking for cash.

Senator Fairbairn: I would like to poke around this murky area a bit more. One thing strikes me about the evolution of the various ways of setting up arrangements with the provinces. When the CHST was brought in, the general feeling among people who do not spend a lot of time delving into these matters was that this was a health transfer. The rest of it is lost in translation. Perhaps that was intentional; I am not sure.

I will repeat a point that has been made by Senator Robertson and the chairman. We still do not know the proportion of the CHST that is spent on health, on education, and on public assistance, do we?

Mr. Bissonnette: You are raising a very deep and important issue. It is not just an issue of accountability; it is an issue about the nature of federalism. I would ask you to allow me to develop that notion.

This transfer currently leaves provinces free to decide what proportions they devote to health versus post-secondary education versus social assistance. The idea, of course, is that different provinces will make different choices. They will make different choices for a number of reasons: perhaps because they have different values; perhaps because they have different needs; perhaps because they feel that a particular social system is well enough developed but that a neighbouring system, say, education, is not. They are given the flexibility to make those choices.

Je ferai une distinction entre l'acceptation du concept de la somme totale que le gouvernement fédéral transfère et l'acceptation du concept des points d'impôt. Il est possible que les deux parties essaient de trouver une formule avantageuse.

J'étais dans l'autre camp en 1977. Je me souviens que les provinces avaient terriblement besoin de ces points d'impôt. J'affirme qu'elles les considèrent toujours comme un élément essentiel du système de répartition.

Le président: Je suppose que vous viviez dans une province riche en 1977, parce que ce n'était pas mon cas ni celui du sénateur Robertson. Nous comprenions également l'énorme faiblesse des points d'impôt. Étiez-vous en Colombie-Britannique, en Alberta ou en Ontario?

Mme Anderson: Je suis certaine que ce n'est pas une question à laquelle je suis tenue de répondre.

Le président: Je vous signale que si vous étiez d'ailleurs, vous auriez une opinion différente.

Le sénateur Robertson: Oui. En 1977, les provinces étaient heureuses qu'on leur remette ces points d'impôt, pour des raisons évidentes. Pendant la guerre, le gouvernement fédéral les a privées d'énormes sommes d'argent mais elles y renonçaient volontiers. J'ignore à quel point elles sont en faveur de l'octroi de points d'impôt supplémentaires. D'après un document qu'ils ont préparé conjointement, les premiers ministres des provinces et les ministres des Finances des territoires ne semblent pas être en faveur de l'octroi de points d'impôt supplémentaires. Ils veulent des transferts en espèces.

Le sénateur Fairbairn: Je voudrais parler encore un peu de cette question équivoque. Ce qui m'a frappée en ce qui concerne l'évolution des accords avec les provinces c'est que, lorsqu'on a introduit le TCSPS, la plupart des personnes qui ne passaient pas leur temps à éplucher ces questions l'ont considéré comme un transfert dans le secteur de la santé. Tout le reste se perdait dans la traduction. C'était peut-être voulu; je ne suis pas sûre.

Je ferai une observation qui a déjà été faite par le sénateur Robertson et par le président. On ne sait toujours pas quelle proportion du TCSPS est consacrée à la santé, à l'éducation et à l'assistance publique. Est-ce bien cela?

M. Bissonnette: Vous abordez un sujet épineux et très important. Ce n'est pas une simple question de responsabilité financière; la nature du fédéralisme est également en jeu. Je voudrais que vous me permettiez de donner des précisions à ce sujet.

Ce transfert laisse actuellement aux provinces la liberté de décider quel pourcentage elles veulent consacrer à la santé, à l'enseignement postsecondaire et à l'assistance sociale. Bien entendu, la décision variera d'une province à l'autre. Les provinces feront des choix différents pour plusieurs raisons, que ce soit parce qu'elles ont des valeurs ou des besoins différents ou parce qu'elles estiment que tel système est suffisamment développé alors qu'un autre, l'enseignement par exemple, ne l'est pas. Elles ont toute la latitude voulue pour faire ces choix.

Of course, it probably has a perceived cost in terms of the accountability for the federal dollars being spent. I recall that Allan Blakeney, who was quite an éminence grise on these fiscal federalism issues, once explaining that there is a fundamental trade-off. If you believe in equalizing opportunity across Canada, if you believe in the federalism principle, which says that if the provinces have certain areas of responsibility we should respect them, if you want to reconcile that with the quality of opportunity principle, to ensure that things are not too different in our hospitals and schools between the various parts of the country, and if you want to respect those first two principles and those first two goals, then you have to be flexible on the issue of accountability. You cannot achieve all three. To achieve perfect accountability, in terms of being able to trace where every federal dollar goes and what those dollars are accomplishing in every province, ultimately, you would need to run the schools and the hospitals for them.

I thought it was quite a deep comment, that there are three principles, three goals, and that if you want to achieve two of them you have to be flexible on the third one; you cannot achieve all three. It is like an impossibility theorem. If you achieve two, the third one must yield a bit.

Senator Fairbairn: I understand the three goals. However, two of those goals are subject to penalty; correct? There is the health part, which is subject to the five principles, and there is the public assistance part, which is subject at least to residency requirements. In the middle is the education part, and it is just sort of there. It is not subject to the same kind of scrutiny, unless it is so within your discussions on the guidelines. You do not have a hammer, at all, on the education part, but you do have one on the other two.

I was present when the CHST was formed, but there is a certain symmetry on the part of two of them, and not in the other. This is not, by any means, a perfect or logically defensible grouping. This is a health study, but at the same time, we have lumped into it the second-most vexing problem for Canadians — post-secondary education. I would like your comment on that.

Ms Anderson: One must go back to the history of the support that the federal government gave in each of those three areas. Federal support for post-secondary education was never of a cost-sharing nature. The support was always given as a block fund.

When federal support for health and post-secondary education were put together, they came from different places in their little universes. It was similar when social assistance was folded in. That was the development of an extremely difficult, exact cost-sharing mechanism, where every penny was accounted for. Thus, the three sectors grew up differently.

Cette formule présente probablement des inconvénients sur le plan de la reddition de comptes. Allan Blakeney, qui était une éminence grise en matière de questions fiscales fédérales-provinciales, a expliqué que c'était un compromis fondamental. Si l'on croit dans l'égalisation des chances pour toutes les régions du Canada et si l'on est convaincu du bien-fondé du principe sur lequel repose le fédéralisme, à savoir que si les provinces ont certains secteurs de compétence, il faut les respecter, si l'on veut concilier ces exigences avec le principe de la qualité des chances et que l'on veut que la qualité des services hospitaliers et des services éducatifs ne varie pas trop d'une région à l'autre, si l'on veut respecter ces deux premiers principes et ces deux premiers objectifs, il faut faire preuve d'une certaine souplesse en matière de responsabilité financière. On ne peut pas concilier totalement les trois. Pour atteindre un degré de reddition de comptes supérieur et pouvoir suivre la trace des investissements fédéraux dans chaque province et en mesurer le rendement, il faudrait administrer les écoles et les hôpitaux à leur place.

Je crois que c'est un commentaire important. Il y a trois principes en jeu ou plutôt trois objectifs, et si l'on veut en atteindre deux, il faut faire un compromis pour le troisième. On ne peut pas concilier totalement les trois. C'est mathématiquement impossible en quelque sorte. Si l'on veut atteindre deux des objectifs, il faut faire quelques concessions en ce qui concerne le troisième.

Le sénateur Fairbairn: Je comprends les trois objectifs. Cependant, si je ne me trompe, deux de ces objectifs sont assujettis à des pénalités. Les paiements de transfert dans le domaine de la santé sont assujettis aux cinq principes et les transferts en matière d'assistance publique sont assujettis aux critères de résidence. Entre les deux, il y a l'enseignement qui n'est pas assujetti à des règles aussi strictes, à moins qu'il n'en soit ainsi dans les discussions sur les lignes directrices. Dans ce domaine, il ne faut pas jouer au gendarme mais dans les deux autres, si.

J'étais présente lorsque le TCSPS a été créé et il y a une certaine symétrie entre deux de ces secteurs alors que ce n'est pas le cas pour le troisième. On ne peut vraiment pas dire que c'est une association parfaite ou défendable sur le plan de la logique. Notre examen porte sur le secteur de la santé mais il nous amène à discuter du problème le plus frustrant pour les Canadiens après celui de la santé, celui de l'enseignement postsecondaire. Je voudrais entendre vos commentaires à ce sujet.

Mme Anderson: Il faut remonter aux origines de l'aide que le gouvernement fédéral a accordée pour chacun de ces trois secteurs. L'aide fédérale en matière d'enseignement postsecondaire n'a jamais été fondée sur le principe du partage des coûts. Elle a toujours été accordée sous forme de transfert global.

Lorsque l'aide fédérale en matière de santé et celle en matière d'enseignement postsecondaire ont été mises sur pied, elles venaient toutes deux de deux univers différents. Ce fut la même chose quand on y a incorporé l'assistance sociale. On a élaboré un mécanisme extrêmement complexe de partage précis des coûts où la moindre dépense devait être justifiée. Par conséquent, les trois secteurs ont suivi un cheminement différent.

Where they meshed was in the understanding that the relationship between governments had changed, had matured, and that block funding, because these programs were established, would provide provinces with the flexibility to allocate among the three sectors. Remember as well where we were when the CHST was established — in the middle of a massive social security review. We wanted the provinces to have the flexibility to design programs that would better match the needs of the future. Hence, that whole evolution of giving them more flexibility came to be.

That is why it is difficult to look back and understand why they do not have the same kind of history. They came from different places.

Senator Fairbairn: I can understand having two of them together under this kind of formula. I sometimes wonder whether education gets value for its money, being part of this threesome, or whether it would do better on its own.

I think there is probably a discipline that has come with the CHST, and I would like that confirmed. We are no longer in a situation where these sums of money that, from the federal perspective, are designated for a certain area end up in another direction, such as road construction, public works or whatever. Under the CHST, this is not something that would easily happen now. Is that correct?

Ms Anderson: A province could, I suppose, stop spending on post-secondary education; hence, one could make the argument that the money we give to them for CHST is, in fact, not going to post-secondary education. They have the flexibility to decide if that is a priority over health, and they have citizens to decide that there has to be some balance between them.

Senator Fairbairn: Still, through that particular door, you could still find that money being used for something other than health, public assistance and education. It is still possible.

Ms Anderson: Once the calculation leaves our building, the money goes to the provincial treasury. We do not trace that exact dollar. There would have to be a situation where there was no spending in a certain area before you could say that there is no money being spent in that area from the CHST.

Senator Banks: I will pursue Senator Fairbairn's question a little bit. I had always assumed that the envelope of this money went to health and social matters in the provinces. If we gave a province \$10 and they spent \$3.33 on each of social services, education and health care, I assumed that if that province reduced the spending in social assistance, say, by \$2.33, down to \$1, then that \$2.33 was now being spent on either post-secondary education or on health. You are saying that they could build roads with it. Is that right?

Ms Anderson: Legally, I suppose that is right.

Ce qui les a réunis, c'est la prise de conscience du fait que la relation entre les gouvernements avait évolué, qu'elle avait mûri et que le financement global, puisque ces programmes étaient établis, accorderait aux provinces la latitude voulue pour répartir elles-mêmes les fonds entre ces trois secteurs. Il ne faut pas oublier que, lorsque le TCSPS a été créé, on était en pleine réforme du système de sécurité sociale. On voulait que les provinces aient la latitude voulue pour concevoir des programmes mieux adaptés à leurs besoins. C'est pourquoi on a commencé à leur donner plus de latitude.

Ce sont les raisons pour lesquelles il est difficile de comprendre pourquoi ces trois secteurs n'ont pas les mêmes antécédents. Leurs origines ne sont pas les mêmes.

Le sénateur Fairbairn: J'admets que l'on applique ce genre de formule à deux d'entre eux. Cependant, je me demande parfois si l'investissement dans l'enseignement se justifie au sein de ce trio ou si le secteur de l'éducation ne devrait pas être géré à part.

Je crois qu'une certaine discipline est associée au TCSPS, et je voudrais que vous le confirmiez. Nous ne sommes plus à l'époque où les fonds fédéraux qui avaient une destination précise pouvaient être utilisés à d'autres fins, notamment pour la construction de routes ou autres travaux publics. Ça ne pourrait plus se produire sous le régime du TCSPS. Est-ce exact?

Mme Anderson: Je suppose qu'une province pourrait cesser d'investir dans l'enseignement postsecondaire. On pourrait donc dire que les fonds accordés dans le cadre du TCSPS ne sont en réalité pas investis dans l'enseignement postsecondaire. Les provinces ont la latitude de décider si l'enseignement postsecondaire doit avoir la priorité sur la santé, et les pressions exercées par les citoyens les aident à établir un certain équilibre entre ces deux secteurs.

Le sénateur Fairbairn: Il est toujours possible que l'argent soit utilisé à d'autres fins que la santé, l'assistance publique ou l'éducation. C'est toujours possible.

Mme Anderson: Lorsque nos calculs sont terminés, les fonds sont transférés dans les caisses des provinces. Nous ne suivons pas la moindre dépense à la trace. Il faudrait qu'il n'y ait aucune dépense dans un secteur donné pour pouvoir dire qu'aucun des fonds du TCSPS n'a été consacré à ce secteur.

Le sénateur Banks: Je pousserai le raisonnement du sénateur Fairbairn un peu plus loin. J'ai toujours supposé que cette enveloppe était consacrée à la santé et aux affaires sociales dans les provinces. Si l'on donnait 10 \$ à une province et qu'elle dépensait 3,33 \$ dans chacun des trois secteurs, à savoir les services sociaux, l'éducation et les soins de santé, j'ai toujours supposé que si elle réduisait ses dépenses en matière d'assistance sociale de 2,33 \$ pour les ramener à 1 \$, ces 2,33 \$ retranchés devaient nécessairement être consacrés au secteur de l'enseignement postsecondaire ou à celui de la santé. Cependant, vous dites qu'elle pourrait investir dans l'infrastructure avec cet argent. Est-ce bien cela?

Mme Anderson: Je suppose que ce serait légal.

Senator Banks: The flexibility is complete.

Mr. Bissonnette: Yes, it is.

Mr. Bissonnette: The flexibility is complete. Again, the way this works is that the provincial treasurers get a cheque. There are no cheques going to education ministers, to social services ministers or to health ministers. In fact, the financial administration acts of all governments forbid that. All money received must flow into the Consolidated Revenue Fund. An appropriation act is required to decide how to allocate that funding.

Every provincial government must face that collective decision of how and where to allocate the federal funds received.

Senator Banks: To put it most simply, we have no control?

Ms Anderson: We have no control about how they allocate that money, no. There is considerable political pressure and there is considerable accountability to citizens. Provincial governments know how much is coming from the federal government, and they know that they have to defend that money as being spent in those three sectors.

Senator Banks: As has been pointed out by other senators, they do not know, because they one story over here and another story over there.

Under what instrument of government is this money distributed to the provinces? Is there a federal-provincial agreement that stipulates the amounts and the means by which this will happen? If so, does that mean the Government of Canada could not, without the approval of the signatories to the agreement, increase the amount spent on the CHST?

Ms Anderson: The Fiscal Arrangements Act is a federal piece of legislation. We certainly consult with provinces regularly, but there is no federal-provincial agreement. It is all done under federal legislation.

Senator Banks: It is largess. I know how absurd that sounds, but it is not subject to any joint agreement. The Government of Canada could, unilaterally, do anything to any of those transfers, in terms of amounts?

Ms Anderson: They could do anything, yes.

The Chairman: In fact, they did. It was one of the problems when the budget-cutting exercises took place.

Senator LeBreton: I am following along on Senator Bank's question. I will go back to the point about Madam Bégin saying that tax points are lost and that we should not talk about them any longer. I have a fundamental problem with that statement. As you point out, tax points is real revenue that the federal government foregoes. No wonder the public is confused.

Do you believe that this whole tax point system has added to the confusion of the public as to knowledge of the level of contribution from the federal government versus the provincial

Le sénateur Banks: Les provinces bénéficient donc d'une latitude totale.

M. Bissonnette: Oui.

M. Bissonnette: Elles bénéficient d'une latitude totale. Les trésoriers des provinces reçoivent un chèque. On n'envoie pas de chèque aux ministres de l'Éducation ni aux ministres des Services sociaux ou aux ministres de la Santé. En fait, les lois sur la gestion des finances publiques de tous les gouvernements excluent le recours à cette formule. Tous les fonds doivent être versés au Trésor. Il faudrait une loi portant affectation de crédits pour faire la répartition de ces fonds.

Tous les gouvernements provinciaux sont confrontés à ce genre de décision; ils doivent se charger de l'affectation des fonds fédéraux qu'ils reçoivent.

Le sénateur Banks: Autrement dit, nous n'avons aucun contrôle. Est-ce bien cela?

Mme Anderson: Nous n'avons aucun contrôle sur l'affectation des fonds. Par contre, les autorités provinciales sont soumises à des pressions politiques considérables et elles doivent rendre des comptes à leurs citoyens. Les gouvernements provinciaux savent combien ils ont reçu du gouvernement fédéral et ils savent qu'ils doivent justifier leurs dépenses dans ces trois secteurs.

Le sénateur Banks: Comme l'ont signalé mes collègues, on n'arrive pas à savoir où vont ces fonds parce que les versions des faits varient.

En vertu de quel mécanisme gouvernemental ces fonds sont-ils distribués aux provinces? Existe-t-il un accord fédéral-provincial qui stipule le montant des transferts et les modalités? Dans ce cas, le gouvernement du Canada n'aurait-il pas la possibilité d'augmenter les sommes consacrées au TCSPS sans l'approbation des parties signataires de l'accord?

Mme Anderson: La Loi sur les arrangements fiscaux est une loi fédérale. Nous consultons les provinces régulièrement mais aucune entente fédérale-provinciale n'a été signée. Le transfert se fait en vertu des dispositions d'une loi fédérale.

Le sénateur Banks: C'est de la largesse. Je sais que ça peut sembler absurde, mais ce système n'a fait l'objet d'aucune entente conjointe. Le gouvernement du Canada pourrait-il décider unilatéralement de modifier le montant de ses transferts?

Mme Anderson: Il pourrait faire ce qu'il veut.

Le président: C'est ce qu'il a fait en réalité. C'était un des problèmes pendant la période de compressions budgétaires.

Le sénateur LeBreton: Je poursuivrai l'interrogatoire du sénateur Banks. Je reviens au point où il a été question de Mme Bégin qui a dit que les points d'impôt étaient en voie de disparition et qu'il ne fallait plus en parler. J'ai une difficulté fondamentale à accepter cette affirmation. Comme vous le signalez, les points d'impôt sont des recettes réelles auxquelles le gouvernement fédéral renonce. Il n'est pas étonnant que ça sème la confusion dans les esprits.

Estimez-vous que ce système de points d'impôt a accentué la confusion quant au niveau de contribution du gouvernement fédéral par rapport à celui des gouvernements provinciaux?

governments? How, in your view, could we simplify this whole discussion, so that the public does understand?

Tax points are tax points. There is one taxpayer. Revenues that the provinces are able to collect directly that the federal government transferred over to them — it is still one taxpayer. Is there some way to aid the public in understanding this? To go back to the chairman's original question, how do we know where that money is being spent? Is there some way that there can be more accountability, without hiring an army of accountants?

Mr. Bissonnette: You are posing two tough and good questions. I will take the second one first, because it is slightly easier, and then I will come back to the first.

The more I reflect about the accountability issue, the less I am convinced that tracing dollars is the way to go. I wonder if the modern accountability doctrines do not have to shift the emphasis from tracing dollars and tracing inputs to measuring results. I sense that the direction we are heading in health care is having all governments report each in their own way, more frequently, more meaningfully, to their constituents on the results that are being achieved with the moneys that they use. Rather than trying to trace federal dollars and find out what they are doing, we are trying to get all jurisdictions, us and provincial governments, to do a better job every year of giving Canadians a sense of what results have been achieved and how much progress was made, based on concrete indicators. It may be that — and I am thinking out loud here — that is a more promising avenue for getting at flexibility.

Coming back to your first question, we have all been grappling with that. We live in a democracy, and it is always upsetting when there is something that cannot be easily understood to Canadians, so that they can form their own judgments. We have been struggling long and hard to find a way of explaining those tax points, of making them concrete, of making them more real. However, it is not an area where we have made much progress.

Ms Anderson: Certainly, we tried to be very clear in all of our public documents regarding the split. We always show the cash, the tax, and the total. However, it is a hard concept — like a lot of the concepts in fiscal arrangements — to make concrete for the average person.

In the post-budget period this year, when there was a lot of focus on a certain province in which we all happen to be sitting at the moment and a concern about tax points, I explained them many times to many reporters in Canada, probably never with much success.

In 1977, we gave approximately \$6 billion to the provinces to support two sectors. At one point, we gave them \$3,000 cash and \$3,000 in tax points. Let us look at it from the point of giving an allowance to a child. Let us assume that one day you say: "I am

Comment pourrait-on simplifier cette discussion de façon à ce que les Canadiens comprennent, à votre avis?

Les points d'impôt sont des points d'impôt. Il n'y a qu'un contribuable. Que les recettes des provinces proviennent de la perception directe d'impôt ou de taxes ou d'un transfert du gouvernement fédéral, c'est toujours le même contribuable qui paie. Y a-t-il moyen d'aider les Canadiens à comprendre cela? Pour revenir à la question initiale du président, comment sait-on à quoi ces fonds sont consacrés? Y a-t-il moyen de rendre davantage de comptes sans recruter une armée de comptables?

M. Bissonnette: Vous posez deux questions qui sont à la fois dures et pertinentes. Je répondrai d'abord à la deuxième, parce que c'est un peu plus facile, puis je répondrai à la première.

Plus je réfléchis à la question de la reddition de comptes, et moins je suis convaincu que ce soit une bonne solution de suivre de près toutes les dépenses. Je me demande si les principes comptables modernes ne doivent pas reposer désormais sur une évaluation des résultats plutôt que sur le dépistage des dépenses et des intrants. Dans le secteur des soins de santé, tous les gouvernements ont tendance à faire état plus souvent et de façon plus précise à leurs électeurs des résultats obtenus grâce à leurs investissements. Au lieu d'essayer de suivre à la trace les fonds fédéraux octroyés aux provinces et de savoir ce qu'elles en font, nous essayons tous ensemble d'informer de mieux en mieux les Canadiens sur les résultats obtenus et les progrès réalisés, d'après des indicateurs concrets. C'est peut-être une formule plus prometteuse pour ce qui est d'assouplir le système; j'avoue que je réfléchis à haute voix.

Pour en revenir à votre première question, nous nous sommes tous interrogés à ce sujet. Nous vivons dans un régime démocratique et il est toujours troublant d'avoir affaire à une formule que les Canadiens ne peuvent pas comprendre facilement et par conséquent sur laquelle ils ne peuvent pas se faire une opinion personnelle. Nous nous efforçons depuis longtemps de trouver un moyen d'expliquer ces points d'impôt et de les rendre plus concrets. Nous n'avons toutefois pas réalisé beaucoup de progrès à cet égard.

Mme Anderson: En tout cas, dans tous les documents publics, nous avons essayé d'indiquer très clairement la ventilation des transferts en espèces, des points d'impôt et le total. C'est une notion qu'il est toutefois difficile de présenter sous une forme concrète au citoyen moyen, à l'instar de la plupart des notions liées aux arrangements fiscaux.

Cette année, au cours de la période postbudgétaire, lorsque la province où nous nous trouvons actuellement faisait l'objet de beaucoup d'attention et que l'on se préoccupait beaucoup de points d'impôt, j'ai expliqué ce concept à maintes reprises à de nombreux journalistes de toutes les régions du pays, probablement sans beaucoup de succès.

En 1977, nous avons octroyé environ 6 milliards de dollars aux provinces pour financer ces deux secteurs. À un certain moment, nous leur avons donné 3 milliards de dollars en espèces et 3 milliards de dollars en points d'impôt. Par exemple, si au lieu

taking you from \$100.00 per month to a car and \$50." That is the concept of tax points.

What happens over time and they develop is very difficult to explain, and both sides can make their arguments. However, the concept of that transfer was a different way of providing exactly the same amount of money, based on perceptions of whether it would make it more sustainable for one side and more advantageous for another side.

There were just as many different perceptions. It was a mechanical way of delivering the exact same support.

Senator LeBreton: Canadians realize that we have an excellent health care system. What undermines and erodes public faith in the system is when Canadians see a political football, with one level of government taking out ads against another level of government. There should be some way of taking the heat out of it and explaining it to people. I know that it is a tall order. We need to explain tax points to Mr. and Mrs. Joe Public. They need some way to understand tax points; it would help ease some of the stress. Most people, if you ask them, cannot cite a personal example of having had a problem with the health care system but do not understand who is, or is not, paying for it.

It goes back to the chair's point. How can we explain to the public that the money is being properly directed to the health care system?

Better minds than most of us have figured this out. It is rather simplistic to say that we should not talk about tax points anymore. They do represent money.

Senator Robertson: They are balanced out.

Senator LeBreton: To not talk about them is like saying that there is no oxygen in the air.

Mr. Bissonnette: This is something that we take very seriously, Senator LeBreton. Recently, I gave a two-hour press backgrounder. We prepared a booklet that goes through the history of these arrangements and the history of the tax points. That backgrounder is available on a Department of Finance Web site.

I got the impression that the journalists who attended left with the feeling that there are generally two legitimate views regarding the same reality, that both viewpoints are legitimate, both show something different, and that neither, in a sense, can debunk the other.

Senator Banks: You have suggested that we have a results-based view of accountability. Perhaps this is simplistic, but it is precisely the results-based view of accountability that is causing problems right now. The results-based view is that hospital wards were not previously shut down because there was not enough money to operate them. Previously, there were not five-month waiting periods for 75-year-olds needing a hip replacement. Now there are waiting periods. That is a results-based assessment that is

d'accorder une allocation de 100 \$ par mois à votre enfant vous lui proposez une voiture et 50 \$ par mois, vous appliquez le même principe que celui sur lequel reposent les points d'impôt.

Avec le temps, cette formule devient très difficile à expliquer et les deux parties ont chacune leur point de vue. Cependant, il s'agissait d'une façon différente de transférer exactement le même montant d'argent parce qu'on estimait que ce serait peut-être plus durable pour une des parties et plus avantageux pour l'autre.

Les perceptions diffèrent d'une personne à l'autre. C'était un moyen mécanique de fournir exactement le même soutien.

Le sénateur LeBreton: Les Canadiens savent que nous avons un excellent système de soins de santé. Ce qui sape leur confiance dans le système, c'est qu'ils le considèrent comme un jeu politique dans le cadre duquel un palier de gouvernement essaie de gagner des points au détriment de l'autre. Il devrait y avoir moyen de calmer les esprits et d'expliquer ce système aux Canadiens. Je sais que c'est un défi de taille que d'expliquer les points d'impôt à monsieur et madame tout-le-monde. Mais il faudrait que les Canadiens comprennent ce système; ça relâcherait la tension. La plupart des Canadiens sont incapables de citer un cas où ils ont eu des problèmes personnels avec le système des soins de santé mais ils ne comprennent pas qui finance le système.

Ça rejoint le commentaire du président. Comment peut-on démontrer aux Canadiens que ces fonds sont bel et bien injectés dans le système des soins de santé?

Des personnes plus compétentes que nous en la matière se sont penchées sur la question. C'est un raisonnement plutôt simpliste que de dire qu'il ne faut plus parler de points d'impôt; ils représentent de l'argent.

Le sénateur Robertson: Ils sont équilibrés.

Le sénateur LeBreton: Éviter d'en parler revient à affirmer qu'il n'y a pas d'oxygène dans l'air.

M. Bissonnette: C'est une question à laquelle nous attachons beaucoup d'importance, madame LeBreton. Dernièrement, j'ai tenu une séance d'information de deux heures devant les journalistes à ce sujet. Nous avons préparé une brochure qui retrace l'historique de ces arrangements et des points d'impôt. Ce document d'information est accessible sur le site Web du ministère des Finances.

J'ai eu l'impression que les journalistes sont ressortis de cette séance d'information convaincus qu'il y avait en général deux opinions légitimes en ce qui concerne la même réalité, que ces deux opinions étaient légitimes mais quelque peu différentes et que l'une ne pouvait pas supplanter l'autre.

Le sénateur Banks: Vous avez dit que notre conception de la responsabilité financière était maintenant axée sur les résultats. C'est peut-être une vue simpliste, mais c'est précisément cette conception qui est la source des problèmes actuels. Autrefois, on ne fermait pas des salles d'hôpital parce que l'on n'avait pas les fonds de fonctionnement nécessaires. Une personne âgée de 75 ans ne devait pas attendre cinq mois pour une arthroplastie de la hanche. Actuellement, il y a des périodes d'attente. C'est une

made by the public. They do understand that. It is difficult to explain the reasons for that.

You mentioned earlier that we would soon approach \$8.1 billion in money actually spent on health care, whereas previously it was \$8.2 billion. I would like to have the rationale of how we painted those dollars pink. I would be very grateful if you could explain to me later, not now, on a piece of paper that we can all have, how it was determined that next year we will spend \$8.1 billion on health care.

Ms Anderson: We can certainly provide some sense of the way in which we calculate it. That is not a problem, but I do have to point out that, under the legislation, there is no allocation between the health, post-secondary education and social assistance.

The numbers did not actually direct anything. It is a block fund, and the provinces decide how to spend their CHST.

Senator Banks: You said that \$8.2 billion had previously been spent on health care and that, next year, the provinces will spend \$8.1 billion. How do we know that?

Ms Anderson: Just to correct that, Mr. Bissonnette was referring to the transfer.

Under EPF, under until 1995-96, we actually did what we call a notional allocation. We said that such and such a percentage of the EPF is for health and that X-percentage is for post-secondary education. Even under EPF, from 1977 to 1995, that had no legal standing. Provinces did not have to spend that money in either of those two sectors. That practice was extended into CHST, but there was no notional allocation done under CHST.

In response to a media campaign by a province this spring, we notionally allocated the health part to explain where that province's number was coming from and where our number was coming from. We can do that. It was a simple calculation, based on the amount that went to health and post-secondary education under EPF. That has no legal standing under the federal law.

The Chairman: The booklet that you talked about I assume contains this notional explanation. Our clerk will get copies of that for us, which will be helpful.

Senator Callbeck: I apologize for being late today. If this area has been covered, I will wait and read it the transcript. My area of concern regards the change to move to equal amounts per capita.

When the CHST was set up, it was based somewhat on the EPF. There was an escalator amount in there, minus a certain percentage. There was a formula.

évaluation basée sur les résultats qui est faite par les Canadiens. Ils comprennent ça. Il est difficile d'expliquer les causes de cette situation.

Vous avez signalé tout à l'heure que les dépenses dans le secteur des soins de santé atteindraient bientôt 8,1 milliards de dollars alors qu'autrefois elles avaient atteint un sommet de 8,2 milliards de dollars. Je voudrais connaître les raisons pour lesquelles ont peint ces dollars en rose. Je vous serais très reconnaissant de m'expliquer plus tard, sur un morceau de papier que l'on pourrait distribuer, comment on a calculé que l'année prochaine, on dépensera 8,1 milliards de dollars dans le secteur de la santé.

Mme Anderson: Nous pouvons expliquer la façon dont nous faisons ce calcul. Ce n'est pas un problème, mais je tiens à signaler que les dispositions de la loi ne parlent pas de répartition entre les secteurs de la santé, de l'enseignement postsecondaire et de l'assistance sociale.

Les chiffres ne donnent en fait aucune précision. Il s'agit d'un transfert global et ce sont les provinces qui décident comment elles dépensent leur TCSPS.

Le sénateur Banks: Vous avez dit qu'il y a plusieurs années, les dépenses consacrées au secteur de la santé avaient atteint 8,2 milliards de dollars et que l'année prochaine, elles atteindront à nouveau 8,1 milliards de dollars. Comment le sait-on?

Mme Anderson: Je tiens à rectifier. M. Bissonnette parlait du transfert.

Sous le régime du FPE, jusqu'en 1995-1996, nous faisons ce que nous appelions une répartition théorique. Nous disions que tel pourcentage du FPE était destiné à la santé et tel pourcentage à l'enseignement postsecondaire. Même sous le régime du FPE, de 1977 à 1995, les provinces n'étaient soumises à aucune contrainte légale; elles n'étaient pas obligées de dépenser le montant prévu dans chacun de ces deux secteurs. Ce principe a été repris dans le TCSPS mais on a cessé de faire une répartition théorique.

À la suite d'une campagne médiatique menée par une province ce printemps, nous avons réparti théoriquement les fonds en ce qui concerne le secteur de la santé pour expliquer les chiffres de la province et les nôtres. Nous pouvons le faire. C'est un calcul facile à faire, qui est basé sur le montant consacré à la santé et à l'enseignement postsecondaire sous le régime du FPE. La loi fédérale n'imposait aucune obligation aux provinces.

Le président: Je suppose que la brochure que vous avez mentionnée contient des explications au sujet de cette répartition théorique. Notre greffière nous en préparera plusieurs exemplaires. Cette brochure nous sera utile.

Le sénateur Callbeck: Je m'excuse d'être arrivée en retard aujourd'hui. Si on a déjà parlé du sujet que je vais aborder, j'attendrai et je lirai le compte rendu des délibérations. Ce qui me préoccupe, c'est la tendance à opter pour des montants égaux par habitant.

Lorsque le TCSPS a été créé, il s'inspirait quelque peu du FPE. Il y avait une clause d'indexation dont on retranchait un certain pourcentage. Il y avait une formule.

In Bill C-71, I think it is, it says that it is going to a per capita amount. Why did the federal government decide to do that?

Ms Anderson: EPF had always been delivered to the provinces on a per capita basis. CAP had very different kinds of allocations.

The Chairman: Just for purposes of our records, CAP is the Canada Assistance Program.

Ms Anderson: The Canada Assistance Program had a different kind of allocation, because it was a cost-matching program.

In the first year that the two were put together, we took provincial shares from the last year of both of those programs, and those were the provincial shares for the first year of the CHST. By definition, it was uneven. Over the years, CAP had become quite uneven, because there had been a cap put on the CAP program. Certain provinces got more than others. There was an unequal presentation of the CHST. Within a year, and after consulting with the provinces, the federal government started to move closer to equal balance per capita. That movement was accelerated in 1999. Does that help?

Senator Callbeck: Did all the provinces agree to this?

Ms Anderson: To the allocation of equal per capita?

Senator Callbeck: To per capita?

Ms Anderson: There is certainly, as I understand it, a difference of opinion among provinces. Some provinces want equal per capita cash, and others want equal per capita entitlements, which is the combination of their cash and tax. Therefore, I would not say that there is a fundamental agreement, but they certainly have accepted it. It has not been an issue for the last two years.

Senator Callbeck: In your estimation, and with your expertise, do you feel that going to per capita is going to be harmful to the smaller provinces?

Ms Anderson: No, it would not be harmful. The manner in which we do the allocation on an equal per capita entitlement basis actually takes into account the different strengths in the province's capacity. The value of their tax points is taken into account, and that means that for the very prosperous provinces tax points are worth more and their cash is less. The less prosperous provinces get more cash per capita.

Senator Callbeck: I do not understand. I thought that, in the year 2001, we would be on a per capita basis, regardless of what the province's tax point was worth. I understood that in Ontario the tax point is worth an awful lot more than in Prince Edward Island, but that, per capita, Ontario would be worth the same amount as Prince Edward Island. Am I wrong in that?

Je crois que c'est dans le projet de loi C-71 qu'il est indiqué qu'il allait être basé sur un certain montant par habitant. Pourquoi le gouvernement fédéral a-t-il pris cette décision?

Mme Anderson: Le FPE a toujours été basé sur un montant par habitant. Le RAPC comprenait divers types d'attributions.

Le président: Je signale pour le compte rendu que RAPC désigne le Régime d'assistance publique du Canada.

Mme Anderson: Le Régime d'assistance publique du Canada comportait un type d'attribution différent parce qu'il s'agissait d'un programme de financement à parts égales.

Au cours de la première année où les deux systèmes ont été jumelés, nous avons pris les parts provinciales de l'année précédente de ces deux programmes et nous les avons réunies pour calculer les parts provinciales de la première année du TCSPS. Les montants variaient automatiquement d'une province à l'autre. Le montant du transfert au titre du RAPC était devenu inégal parce qu'un plafond avait été imposé. Certaines provinces recevaient davantage que d'autres. Le TCSPS était donc fondé sur un système inégal. En l'espace d'un an, et après avoir consulté les provinces, le gouvernement fédéral a commencé à égaliser le système en se basant sur les allocations par habitant. Ce mouvement s'est accéléré en 1999. Ces explications vous aident-elles à comprendre?

Le sénateur Callbeck: Toutes les provinces étaient-elles d'accord?

Mme Anderson: Au sujet de l'attribution d'un montant égal par habitant?

Le sénateur Callbeck: Au sujet d'un système d'octroi d'un montant par habitant?

Mme Anderson: Si je comprends bien, les opinions varient d'une province à l'autre. Certaines provinces veulent un transfert en espèces d'un montant égal par habitant et d'autres veulent des droits égaux par habitant, qui constituent une combinaison des transferts en espèces et des transferts de points d'impôt. Par conséquent, je ne dirais pas qu'il y ait un consensus, mais elles ont accepté le changement. Nous n'avons plus entendu de doléances à ce sujet depuis deux ans.

Le sénateur Callbeck: À la lumière de vos connaissances, estimez-vous que le système par habitant sera désavantageux pour les petites provinces?

Mme Anderson: Non, il ne le sera pas. Dans le contexte de l'attribution en fonction de droits égaux par habitant, nous tenons compte de divers points forts de la capacité de la province. La valeur de ses points d'impôt est prise en considération, ce qui signifie qu'en ce qui concerne les provinces prospères, les points d'impôt ont plus de valeur et que les transferts en espèces sont moins élevés. Les provinces moins prospères reçoivent un montant en espèces plus élevé par habitant.

Le sénateur Callbeck: Je ne comprends pas. Je pensais qu'en 2001, le système de calcul par habitant serait en vigueur. Peu importe la valeur des points d'impôt. Si j'ai bien compris, en Ontario, le point d'impôt vaut beaucoup plus qu'un point d'impôt à l'Île-du-Prince-Édouard alors que par habitant, la valeur serait la même pour les deux provinces. Est-ce bien cela?

Ms Anderson: Each province is on an entitlement basis, so that the total CHST — cash and tax — will be exactly equal in every province. That is what will be equal. It is not a per capita cash allocation but rather a per capita entitlement, which is the total.

Senator Callbeck: I was looking at a document from the parliamentary research branch that refers to dollars per capita. I did not think the tax points were in there, but they are.

Senator Robertson: Returning to the tax points, Mr. Chairman, I will give an example. If you were to give me \$100 a month for 10 years, and then if I were to pay back the \$100 per month for 10 years, we would be pretty well equal, excepting for the interest, would we not?

The Chairman: That is right.

Senator Robertson: Thank you. The CHST does not grow, as I understand it, with the province's economy, or does it? I am not quite sure, but I thought that it did not grow.

Mr. Bissonnette: Let us remember that this transfer has two components. It has a cash component and a tax component. The tax point component grows at roughly the rate of the economy. In fact, sometimes it can even exceed the rate of growth of the economy. The cash portion of the transfer, for Canada as a whole, is actually set out as a five-year track in the legislation. The parameters are laid out for every year.

Senator Robertson: I understand; however, I am not talking about tax points. What was the cash portion per capita in 1994-95? If you do not have those figures now, I will be glad to accept them later.

Mr. Bissonnette: We may have them here. I will check.

Senator Robertson: While you are looking through that, I want to know the cash portion per capita today.

Mr. Bissonnette: Is that for the CHST?

Senator Robertson: Yes. I want the cash portion, not the tax points. Also, what were the payments that were made by the provinces for health care per person in 1994-95. That figure should be the cash portion only, please.

Mr. Bissonnette: Is that for provincial health care spending in 1994-95? I do not believe that we have that with us. I believe that you had a witness, Mr. Cliff Halliwell, from Health Canada, who, I think, gave you two booklets that had the entire provincial spending information.

The Chairman: We can get that.

Senator Robertson: As long as I get this information sometime, that would be fine. I would like to know if you have any projections on what the provinces will be spending on health care five years out and ten years out. Does your projection include the aging population and the demographics? Working with the

Mme Anderson: Le calcul pour chaque province est basé sur les droits et, par conséquent, le montant total du TCSPS — c'est-à-dire le transfert en espèces et le transfert de points d'impôt — est exactement le même pour chaque province. Il ne s'agit pas d'allocations en espèces par habitant mais plutôt de droits par habitant.

Le sénateur Callbeck: J'ai examiné un document préparé par la Direction de la recherche parlementaire de la Bibliothèque du Parlement où il est question du montant par habitant. Je ne pensais pas que les points d'impôt intervenaient mais c'est le cas.

Le sénateur Robertson: Monsieur le président, je voudrais citer un exemple à propos des points d'impôt. Si vous me donnez 100 \$ par mois pendant 10 ans et que je devais rembourser les 100 \$ par mois pendant 10 ans, ça reviendrait pratiquement au même, sauf en ce qui concerne l'intérêt. Est-ce bien cela?

Le président: C'est exact.

Le sénateur Robertson: Merci. Le TCSPS ne suit pas la même progression que l'économie de la province concernée, si j'ai bien compris. Je n'en suis pas sûre mais je pensais qu'il n'augmentait pas.

M. Bissonnette: Il ne faut pas oublier que ce transfert comporte deux volets. Il comporte un transfert en espèces et un transfert de points d'impôt. En ce qui concerne les points d'impôt, l'accroissement est pour ainsi dire égal au taux d'expansion économique. En fait, il peut même parfois lui être supérieur. Quant au transfert en espèces, il est fixé pour cinq ans dans la loi pour l'ensemble du pays. Les paramètres sont établis pour chaque année.

Le sénateur Robertson: Je comprends; cependant, je ne parle pas de points d'impôt. Quel était le montant en espèces par personne en 1994-1995? Si vous n'avez pas ces chiffres sous la main, j'accepterai que vous me les communiquiez plus tard.

M. Bissonnette: Nous les avons peut-être tous ici. Je vérifierai.

Le sénateur Robertson: Pendant que vous vérifiez, je voudrais savoir quel est, présentement, le montant en espèces par habitant.

M. Bissonnette: Est-ce pour le TCSPS?

Le sénateur Robertson: Oui. En ce qui concerne le transfert en espèces et pas les points d'impôt. Je voudrais également savoir quel est le montant par habitant des versements qui ont été faits par les provinces pour les soins de santé en 1994-1995. Ne me donnez que le montant des versements en espèces.

M. Bissonnette: Est-ce pour les dépenses provinciales dans le secteur des soins de santé en 1994-1995? Je ne crois pas que nous ayons ces chiffres ici. Je crois qu'un des témoins, M. Cliff Halliwell, de Santé Canada, vous a remis deux brochures contenant des renseignements complets sur les dépenses provinciales.

Le président: Nous pourrions les obtenir.

Le sénateur Robertson: C'est très bien, pourvu que j'aie ce renseignement un jour ou l'autre. Je voudrais savoir si vous avez fait des prévisions sur le montant des dépenses que feront les provinces dans le secteur des soins de santé d'ici cinq et dix ans. Vos prévisions tiennent-elles compte du vieillissement de la

provinces, are you looking ahead to where this expenditure will be in five or ten years?

My last question pertains to statistical matters. If the federal government had not brought in the CHST, if the existing restraints on EPF and CAP had expired as scheduled in 1995-96, if programs had reverted to the old formula, as they were supposed to come back but then we changed to the CHST, and if EPF and CAP had kicked back in again, what would you now be sending to the provinces in cash under the EPF and CAP programs?

Mr. Bissonnette: Could I ask you to rephrase that? That was a complicated question.

Senator Robertson: If the federal government had not brought in the CHST and if the existing restraints on EPF and CAP had expired as scheduled — we had kept established programs financing and CAP and they had expired as scheduled in 1995-96 — the programs, then, would revert to the old formula. What would you now send to the provinces in cash under the EPF-CAP formula? In this instance, I am suggesting that CHST had not been introduced in the middle. CHST was introduced when EPF-CAP was supposed to come back to its original formulation. I do not expect the answers now, but I would like to have that information.

Ms Anderson: We will certainly add those. The last one is very difficult because it is such a hypothetical situation. However, we will try.

The Chairman: I am not sure that it is any more hypothetical than the way you arrive at your number for health care spending. In any event, I would not want to pursue that.

Senator Robertson: I want to pursue those figures.

The Chairman: Thank you both for coming. You have been very helpful.

I think, Mr. Bissonnette, that your comment is correct, that there are two legitimate points of view on the tax points question and that there is no way of reaching the so-called absolute truth, in the sense of proving one position right or wrong. It is a wonderful indication of the non-partisan nature of most Senate committees, and this one in particular. For example, we have Senator Robertson and Senator LeBreton of the same party but with conflicting views. We also had Mr. Marc Lalonde and Ms Monique Bégin of the same party with sharply conflicting opinions on the tax points question.

It is amazing to me that outcomes measurement in the health care field, such as the performance of hospitals, other than the sort of observable evidence that Senator Banks talked about, has never historically been done until only recently. In the last two years, the Ontario Hospital Association attempted to measure the performance of hospitals. It has been an input measurement for business

population et autres considérations d'ordre démographique? Essayez-vous de prévoir, avec l'aide des provinces, à combien s'élèveront ces dépenses dans cinq ou dix ans?

Ma dernière question concerne les calculs. Si le gouvernement fédéral n'avait pas instauré le TCSPS, si les compressions imposées sur le FPE et le RAPC étaient venues à échéance, comme prévu, en 1995-1996, si l'ancienne formule avait été rétablie comme prévu au lieu d'être remplacée par le TCSPS et si le FPE et le RAPC existaient toujours, quel montant en espèces transféreriez-vous aux provinces en vertu de ces deux programmes?

M. Bissonnette: Pourrais-je vous demander de formuler à nouveau votre question? Elle est compliquée.

Le sénateur Robertson: Si le gouvernement fédéral n'avait pas instauré le TCSPS et si les restrictions imposées sur le FPE et le RAPC étaient venues à expiration dans les délais prévus — c'est-à-dire si ces deux programmes avaient été maintenus et si les restrictions avaient été levées, comme prévu, en 1995-1996 — l'ancienne formule aurait été rétablie. Quel montant en espèces transféreriez-vous maintenant aux provinces si la formule du FPE et du RAPC avait été maintenue? Autrement dit, je pars du principe que le TCSPS n'aurait pas été instauré entre-temps. En effet, il a été instauré au moment où la formule initiale était censée être rétablie pour le FPE et le RAPC. Je ne demande pas nécessairement une réponse immédiate, mais je voudrais avoir ce renseignement.

Mme Anderson: Nous ferons ces calculs. Le dernier sera très difficile parce que c'est une situation très hypothétique. Nous essayerons cependant.

Le président: Je ne suis pas sûr que ce soit plus hypothétique que la façon dont vous calculez le montant des dépenses dans le secteur des soins de santé. De toute façon, je ne tiens pas à insister là-dessus.

Le sénateur Robertson: Je tiens à obtenir ces chiffres.

Le président: Merci d'être venus. Vous nous avez donné des renseignements très utiles.

Monsieur Bissonnette, je crois que vous avez raison de dire qu'il y a deux points de vue légitimes sur la question des points d'impôt et qu'il est absolument impossible d'établir la vérité absolue, c'est-à-dire de prouver qu'un point de vue est plus valable que l'autre. C'est une belle preuve de la nature non sectaire de la plupart des comités sénatoriaux, et du nôtre en particulier. Le sénateur Robertson et le sénateur LeBreton ont exprimé par exemple des opinions contradictoires alors qu'elles appartiennent au même parti. Par ailleurs, M. Marc Lalonde et Mme Monique Bégin ont des opinions très divergentes en ce qui concerne la question des points d'impôt alors qu'ils sont membres du même parti.

Je suis étonné que l'on n'ait commencé que depuis peu à évaluer les résultats, et notamment le rendement des hôpitaux, dans le secteur des soins de santé. Le sénateur Banks a dit qu'on n'avait commencé à le faire que depuis peu. Au cours des deux dernières années, l'Ontario Hospital Association a essayé d'évaluer le rendement des hôpitaux. Il s'agissait d'une évaluation

— how much money, how many nurses, how many beds — but we did not attempt to measure outputs.

Any attempt at measuring outputs would be a significant improvement relative to where we are now. It is an extremely difficult thing to do, but, in the end, there is no other business in the world that would measure its performance on the basis of inputs other than the health care system. That is not unique to the federal government; it is just a comment on the system.

You may want to think about this. I understand that one must achieve a balance, as you put it. There are things that you give away when you go to block funding versus tied funding. You get more flexibility, but on the other hand, you get less ability to direct the money. There is a trade-off.

I come from the federal-provincial area of the 1970s and early 1980s, which was more directive and less flexible than the late 1980s and 1990s. It does seem to me, for example, that we have gone too far in the flexible direction.

We read in the newspapers that there is a significant shortage of MRI machines and other technologies across the country. Am I correct that under the current system in thinking that, if the federal government wanted to contribute money specifically and solely for the purchase of MRI machines, unless it did it from some new program it could not be done? If the federal government said they wanted to put \$400 million into new MRI machines, for example, it could not be done under existing programs; am I correct?

Ms Anderson: Mr. Chairman, we could and did in 1999 designate a certain amount of money under the legislation for health.

The Chairman: We will agree to disagree on how much of that was smoke and mirrors.

Ms Anderson: We did not say that if the province did not buy MRIs, for example, the money would be taken back. The legislation is flexible enough to have a purpose clause in it, backed up by provincial agreement, perhaps, as we did in 1999, to put money towards things like that. The legislation would not vis-à-vis the kind of withholding provisions that we have for the Canada Health Act on that kind of a commitment.

The Chairman: Therefore, the answer to my question is yes. A deal that is not enforceable is not that great a deal. As I understand you, the federal government could say that we only want this money spent on MRI machines, and the provinces can agree and take the money but not spend it on MRIs. There would be nothing that the federal government could do about it, from the legal standpoint. Do I understand you correctly?

Senator LeBreton: Could you not withhold any funds?

Ms Anderson: That is another step. We would need to amend the legislation to withhold further funds.

des intrants — coûts, nombre d'infirmières, nombre de lits — mais nous n'avons pas essayé d'évaluer les extrants.

Toute tentative de calcul des extrants représenterait une amélioration importante par rapport à ce que nous avons fait. C'était une opération extrêmement difficile mais, en fin de compte, l'évaluation du rendement en fonction des intrants n'est possible dans aucun autre secteur que celui des soins de santé. Ce raisonnement ne s'applique pas uniquement au gouvernement fédéral, mais à tout le système.

Vous pourriez peut-être y réfléchir. Si j'ai bien compris, il faut faire un certain compromis, comme vous l'avez si bien dit. Il faut faire des concessions quand on opte pour la formule de financement global plutôt que pour celle du financement conditionnel. On y gagne en latitude mais on a moins de contrôle sur la destination des fonds. Il y a des concessions à faire.

Dans les années 70 et au début des années 80, les transferts fédéraux-provinciaux étaient plus dirigés et moins souples que vers la fin des années 80 et au cours des années 90. J'ai l'impression que nous sommes peut-être allés un peu trop loin en matière de souplesse.

D'après les journaux, il y a beaucoup trop peu d'appareils d'imagerie par résonnance magnétique et d'appareils faisant appel à d'autres technologies dans nos établissements hospitaliers. Ai-je raison de penser que si le gouvernement fédéral voulait octroyer des fonds destinés spécifiquement à l'achat de tels appareils, ce serait impossible sans créer un nouveau programme? Est-il exact que si le gouvernement fédéral décidait d'investir 400 millions de dollars dans l'achat d'appareils IRM neufs, par exemple, il ne pourrait pas le faire dans le cadre des programmes actuels?

Mme Anderson: Monsieur le président, en 1999, nous avons donné une destination spécifique à certaines subventions en vertu de la législation sur la santé.

Le président: Nous nous permettons le droit de penser que c'était en grande partie de la frime.

Mme Anderson: Nous n'avons pas dit par exemple que nous récupérerions les fonds si la province n'achetait pas les appareils en question. La législation est assez souple pour inclure des dispositions de déclaration d'objet, appuyées par une entente avec la province concernée, qui nous permettent de donner une destination spécifique aux fonds que nous accordons, comme nous l'avons fait en 1999. La législation ne contient pas de disposition d'exclusion comme la Loi canadienne sur la santé à cet égard.

Le président: Par conséquent, la réponse à ma question est affirmative. Un marché que l'on ne peut obliger l'autre partie à respecter n'est pas un très bon marché. Si j'ai bien compris, le gouvernement fédéral pourrait seulement émettre le désir que l'argent soit consacré à l'achat d'appareils IRM et les provinces pourraient accepter l'argent sans toutefois l'utiliser à cette fin. Le gouvernement fédéral n'aurait aucun recours légal. Est-ce bien cela?

Le sénateur LeBreton: Ne pourriez-vous pas retenir ces fonds?

Mme Anderson: C'est une autre étape. Il faudrait modifier la loi pour pouvoir le faire.

The Chairman: I understand that Mr. Marc Lalonde made a very good case of why we were too rigid in the old days. I would argue that we have become too flexible. That is an issue for another day.

Thank you for attending here. We appreciate you taking the time to be with us. You were very helpful.

The committee adjourned.

Le président: En résumé, M. Marc Lalonde a très bien expliqué les raisons pour lesquelles nous étions trop stricts autrefois. Je dirais que nous sommes devenus trop laxistes. Nous en parlerons toutefois un autre jour.

Merci d'être venus. Nous apprécions le fait que vous nous ayez consacré une partie de votre temps. Vous nous avez beaucoup aidés.

La séance est levée.



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WITNESSES—TÉMOINS

From the Department of Finance:

Guillaume Bissonnette, General Director, Federal-Provincial
Relations and Social Policy Branch;

Barbara Anderson, Director, Federal-Provincial Relations
Division, Federal-Provincial Relations and Social Policy
Branch.

Du Ministère des finances:

Guillaume Bissonnette, directeur général, Direction générales
des relations fédérales-provinciales et de la politique
sociale;

Barbara Anderson, directrice, Division des relations
fédérales-provinciales, Direction générale des relations
fédérales-provinciales et de la politique sociale.



Second Session
Thirty-sixth Parliament, 1999-2000

SENATE OF CANADA

*Proceedings of the Standing
Senate Committee on*

Social Affairs, Science and Technology

Chairman:
The Honourable MICHAEL KIRBY

Tuesday, June 20, 2000
Wednesday, June 21, 2000

Issue No. 18

First, second and last meetings on:

Bill C-12, An Act to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other Acts
and

Second and last meeting on:

Bill S-5, An Act to amend the Parliament of Canada Act (Parliamentary Poet Laureate)

INCLUDING:

THE EIGHTH AND NINTH REPORTS OF THE COMMITTEE (Bill C-12 and Bill S-5)

APPEARING:

The Honourable Claudette Bradshaw, P.C., M.P.,
Minister of Labour

WITNESSES:
(See back cover)

Deuxième session de la
trente-sixième législature, 1999-2000

SÉNAT DU CANADA

*Délibérations du comité
sénatorial permanent des*

Affaires sociales, des sciences et de la technologie

Président:
L'honorable MICHAEL KIRBY

Le mardi 20 juin 2000
Le mercredi 21 juin 2000

Fascicule n° 18

Première, deuxième et dernière réunions concernant:

Le projet de loi C-12, Loi modifiant la partie II du Code canadien du travail, portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquences
et

Deuxième et dernière réunion concernant:

Le projet de loi S-5, Loi modifiant la Loi sur le Parlement du Canada (poète officiel du Parlement)

Y COMPRIS:

LES HUITIÈME ET NEUVIÈME RAPPORTS DU COMITÉ (les projets de loi C-12 et S-5)

COMPARAÎT:

L'honorable Claudette Bradshaw, c.p., députée,
ministre du Travail

TÉMOINS:
(Voir à l'endos)

THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Fairbairn
Beaudoin	Keon
* Boudreau, P.C. (or Hays)	* Lynch-Staunton
Callbeck	(or Kinsella)
Carstairs	Pépin
Cohen	Robertson
Cook	

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Banks substituted for that of the Honourable Senator Bryden (*June 21, 2000*).

The name of the Honourable Senator Fairbairn substituted for that of the Honourable Senator Wiebe (*June 21, 2000*).

The name of the Honourable Senator Beaudoin substituted for that of the Honourable Senator DeWare (*June 21, 2000*).

The name of the Honourable Senator Keon substituted for that of the Honourable Senator Kinsella (*June 21, 2000*).

The name of the Honourable Senator Carstairs substituted for that of the Honourable Senator F. Robichaud (*June 21, 2000*).

The name of the Honourable Senator DeWare substituted for that of the Honourable Senator Beaudoin (*June 20, 2000*).

The name of the Honourable Senator Kinsella substituted for that of the Honourable Senator Keon (*June 20, 2000*).

The name of the Honourable Senator Bryden substituted for that of the Honourable Senator Banks (*June 20, 2000*).

The name of the Honourable Senator Banks substituted for that of the Honourable Senator Gill (*June 15, 2000*).

The name of the Honourable Senator Gill substituted for that of the Honourable Senator Ferretti Barth (*June 15, 2000*).

The name of the Honourable Senator Wiebe substituted for that of the Honourable Senator Fairbairn (*June 14, 2000*).

The name of the Honourable Senator F. Robichaud substituted for that of the Honourable Senator Carstairs (*June 14, 2000*).

The name of the Honourable Senator Fairbairn substituted for that of the Honourable Senator Corbin (*June 12, 2000*).

The name of the Honourable Senator Pépin substituted for that of the Honourable Senator Banks (*June 8, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES AFFAIRES SOCIALES, DES SCIENCES ET DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjory LeBreton

et

Les honorables sénateurs:

Banks	Fairbairn
Beaudoin	Keon
* Boudreau, c.p. (ou Hays)	* Lynch-Staunton
Callbeck	(ou Kinsella)
Carstairs	Pépin
Cohen	Robertson
Cook	

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Banks est substitué à celui de l'honorable sénateur Bryden (*le 21 juin 2000*).

Le nom de l'honorable sénateur Fairbairn est substitué à celui de l'honorable sénateur Wiebe (*le 21 juin 2000*).

Le nom de l'honorable sénateur Beaudoin est substitué à celui de l'honorable sénateur DeWare (*le 21 juin 2000*).

Le nom de l'honorable sénateur Keon est substitué à celui de l'honorable sénateur Kinsella (*le 21 juin 2000*).

Le nom de l'honorable sénateur Carstairs est substitué à celui de l'honorable sénateur F. Robichaud (*le 21 juin 2000*).

Le nom de l'honorable sénateur DeWare est substitué à celui de l'honorable sénateur Beaudoin (*le 20 juin 2000*).

Le nom de l'honorable sénateur Kinsella est substitué à celui de l'honorable sénateur Keon (*le 20 juin 2000*).

Le nom de l'honorable sénateur Bryden est substitué à celui de l'honorable sénateur Banks (*le 20 juin 2000*).

Le nom de l'honorable sénateur Banks est substitué à celui de l'honorable sénateur Gill (*le 15 juin 2000*).

Le nom de l'honorable sénateur Gill est substitué à celui de l'honorable sénateur Ferretti Barth (*le 15 juin 2000*).

Le nom de l'honorable sénateur Wiebe est substitué à celui de l'honorable sénateur Fairbairn (*le 14 juin 2000*).

Le nom de l'honorable sénateur F. Robichaud est substitué à celui de l'honorable sénateur Carstairs (*le 14 juin 2000*).

Le nom de l'honorable sénateur Fairbairn est substitué à celui de l'honorable sénateur Corbin (*le 12 juin 2000*).

Le nom de l'honorable sénateur Pépin est substitué à celui de l'honorable sénateur Banks (*le 8 juin 2000*).

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Thursday, June 15, 1999:

Second reading of Bill C-12, An Act to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other Acts.

The Honourable Senator Bryden moved, seconded by the Honourable Senator Chalifoux, that the bill be read the second time.

After debate,

The question being put on the motion, it was adopted.

The bill was then read the second time.

The Honourable Senator Hays moved, seconded by the Honourable Senator Squires, that the bill be referred to the Standing Senate Committee on Social Affairs, Science and Technology.

The question being put on the motion, it was adopted.

ORDRE DE RENVOI

Extrait des *Journaux du Sénat* du lundi 6 décembre 1999:

Deuxième lecture du projet de loi C-12, Loi modifiant la partie II du Code canadien du travail, portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquence.

L'honorable sénateur Bryden propose, appuyé par l'honorable sénateur Chalifoux, que le projet de loi soit lu la deuxième fois.

Après débat,

La motion, mise aux voix, est adoptée.

Le projet de loi est alors lu la deuxième fois.

L'honorable sénateur Hays propose, appuyé par l'honorable sénateur Squires, que le projet de loi soit renvoyé au comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

La motion, mise aux voix, est adoptée.

Le greffier du Sénat,

Paul Bélisle

Clerk of the Senate

MINUTES OF PROCEEDINGS

OTTAWA, Tuesday, June 20, 2000

(25)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in Room 705, Victoria Building, at 5:03 p.m., the Chair, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Bryden, DeWare, Carstairs, Cohen, Cook, Kirby, LeBreton, Pépin and Robertson (9).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore.

Also in attendance: The official reporters of the Senate.

APPEARING:

The Honourable Claudette Bradshaw, P.C., M.P., Minister of Labour.

WITNESSES:

Human Resources Development Canada:

Narren Edmonson, Assistant Deputy Minister, Labour;

Gerry Blanchard, Director General, Labour Operations;

Bill Worona, Director, Occupational Safety and Health and Fire Prevention;

Rick Seamen, Program Advisor, Occupational Safety and Health Compliance Unit;

Pursuant to the Order of Reference adopted by the Senate on Thursday, June 15, 2000, the committee began its consideration of the Bill C-12, An Act to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other Acts.

The Chairman made a statement.

The minister made a statement, and together with the witnesses, answered questions.

At 5:40 p.m., the committee adjourned to the call of the Chair.

ATTEST:

OTTAWA, Wednesday, June 21, 2000

(26)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in Room 705, Victoria Building, at 3:40 p.m., the Chair, the Honourable Michael Kirby, presiding.

PROCÈS-VERBAUX

OTTAWA, le mardi 20 juin 2000

(25)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 17 h 03, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Bryden, DeWare, Carstairs, Cohen, Cook, Kirby, LeBreton, Pépin et Robertson (9).

Également présente: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

COMPARAÎT:

L'honorable Claudette Bradshaw, c.p., députée, ministre du Travail.

TÉMOINS:

Développement des ressources humaines Canada — Programme du travail:

Warren Edmonson, sous-ministre adjoint, Travail;

Gerry Blanchard, directeur général, Opération du travail;

Bill Worona, directeur, Sécurité et santé au travail et prévention des incendies;

Rick Seaman, conseiller de programme, Unité d'observation de l'hygiène et de la sécurité du travail.

En conformité avec l'ordre de renvoi adopté par le Sénat le jeudi 15 juin 2000, le comité entame l'étude du projet de loi C-12, Loi modifiant la partie II du Code canadien du travail, portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquence.

Le président fait une déclaration.

La ministre fait un exposé puis, avec les autres témoins, répond aux questions.

À 17 h 40, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

OTTAWA, le mercredi 21 juin 2000

(26)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 15 h 40, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Members of the committee present: The Honourable Senators Callbeck, Carstairs, Cohen, Cook, Fairbairn, Kirby, LeBreton, Pépin, Robertson (9).

Other senators present: The Honourable Senators Gill and Grafstein (2).

In attendance: From the Research Branch of the Library of Parliament: June M. Dewetering and Odette Madore

Also in attendance: The official reporters of the Senate.

WITNESSES:

Canadian Labour Congress:

Hassan Yussuff, Executive Vice-President.

Canadian Union of Postal Workers:

Jeff Bennie, National Union Representative.

Public Service Alliance of Canada:

Denis St-Jean, Health and Safety Officer.

Federally Regulated Employers — Transportation and Communications (FETCO):

Don Brazier, Executive Director

Pursuant to the Order of Reference adopted by the Senate on Thursday, June 15, 2000, the committee continued its consideration of the Bill C-12, An Act to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other Acts.

The Chairman made a statement.

Mr. Yussuff made a statement. Mr. Brazier made a statement. The witnesses answered questions.

It was moved by Senator LeBreton — That the committee dispense with clause-by-clause consideration of Bill C-12.

The question being put on the motion, it was adopted.

It was moved by Senator LeBreton — That Bill C-12 be reported to the Senate without amendment.

The question being put on the motion, it was adopted.

Pursuant to the Order of Reference adopted by the Senate on Tuesday, February 22, 2000, the Committee continued its consideration of Bill S-5, An Act to amend the Parliament of Canada Act (Parliamentary Poet Laureate). (*For complete text of Order of Reference see Proceedings of the Committee, Issue No. 10.*)

It was moved by Senator Carstairs — That the committee dispense with clause-by-clause consideration of Bill S-5.

The question being put on the motion, it was adopted.

It was moved by Senator Fairbairn — That Bill S-5 be reported to the Senate without amendment.

The question being put on the motion, it was adopted.

Membres du comité présents: Les honorables sénateurs Callbeck, Carstairs, Cohen, Cook, Fairbairn, Kirby, LeBreton, Pépin et Robertson (9).

Autres sénateurs présents: Les honorables sénateurs Gill et Grafstein (2).

Également présentes: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: June M. Dewetering et Odette Madore.

Aussi présents: Les sténographes officiels du Sénat.

TÉMOINS:

Du Congrès du travail du Canada:

Hassan Yussuff, vice-président directeur

Du Syndicat des travailleurs et travailleuses des postes du Canada:

Jeff Bennie, représentant syndical national.

De l'Alliance de la fonction publique du Canada:

Denis St-Jean, agent en santé et sécurité.

D'Employeurs des transports et communications de régie fédérale (ETCOF):

Don Brazier, directeur exécutif.

En conformité avec l'ordre de renvoi adopté par le Sénat le jeudi 15 juin 2000, le comité entame l'étude du projet de loi C-12, Loi modifiant la partie II du Code canadien du travail, portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquence.

Le président fait une déclaration.

M. Yussuf fait un exposé. M. Brazier fait un exposé. Les témoins répondent aux questions.

Il est proposé par le sénateur LeBreton — Que le comité se passe de faire l'étude article par article du projet de loi C-12.

La question, mise aux voix, est adoptée.

Il est proposé par le sénateur LeBreton — Qu'il soit fait rapport au du projet de loi C-12 sans modification.

La question, mise aux voix, est adoptée.

Conformément à l'ordre de renvoi daté du 22 février 2000, le comité poursuit l'examen du projet de loi S-5, Loi modifiant la Loi sur le Parlement du Canada (poète officiel du Parlement). (*Voir le texte complet de l'ordre de renvoi dans le fascicule n° 10 des délibérations du comité.*)

Il est proposé par le sénateur Carstairs — Que le comité se passe de faire l'étude article par article du projet de loi S-5.

La question, mise aux voix, est adoptée.

Il est proposé par le sénateur Fairbairn — Qu'il soit fait rapport au Sénat du projet de loi S-5 sans modification.

La question, mise aux voix, est adoptée.

At 4:07 p.m., the committee adjourned to the call of the Chair.

À 16 h 07, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTEST:

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

REPORTS OF THE COMMITTEE

Thursday, June 22, 2000

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to present its

EIGHTH REPORT

Your Committee, to which was referred Bill C-12, An Act to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other Acts, in obedience to the Order of Reference of Thursday, June 15, 2000, has examined the said bill and now reports the same without amendment.

Respectfully submitted,

Thursday, June 22, 2000

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to present its

NINTH REPORT

Your Committee, to which was referred Bill S-5, An Act to amend the Parliament of Canada Act (Parliamentary Poet Laureate), in obedience to the Order of Reference of Tuesday, February 22, 2000, has examined the said bill and now reports the same without amendment.

Respectfully submitted,

Le président,

MICHAEL KIRBY

Chairman

RAPPORTS DU COMITÉ

Le jeudi 22 juin 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de présenter son

HUITIÈME RAPPORT

Votre comité, auquel a été déféré le Projet de loi C-12, Loi modifiant la partie II du Code canadien du travail, portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquence, conformément à l'ordre de renvoi du jeudi 15 juin 2000, a étudié ledit projet de loi et en fait maintenant rapport sans modifications.

Respectueusement soumis,

Le jeudi 22 juin 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de présenter son

NEUVIÈME RAPPORT

Votre comité, auquel a été déféré le Projet de loi S-5, Loi modifiant la Loi sur le Parlement du Canada (poète officiel du Parlement), conformément à l'ordre de renvoi du mardi 22 février 2000, a étudié ledit projet de loi et en fait maintenant rapport sans modifications.

Respectueusement soumis,

EVIDENCE

OTTAWA, Tuesday, June 20, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill C-12, to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other Acts, met this day at 5:03 p.m. to give consideration to the bill.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Our witness today is the Minister of Labour, the Honourable Claudette Bradshaw, who has a number of officials with her.

The minister has an ear infection. Therefore, she must drive to Moncton tonight in order to meet with the Premier of New Brunswick tomorrow rather than fly. I hope we can be reasonably expeditious in our questions.

Minister, thank you for taking the time to be with us. Please proceed.

Hon. Claudette Bradshaw, Minister of Labour: Before I begin, I wish to thank you for understanding the schedule and meeting tonight and not tomorrow. It is very much appreciated.

Honourable senators, I am pleased to speak to you today on Bill C-12, amending Part II of the Canada Labour Code. As we debate the amendments that will influence the safety and health of our workplaces, we should remember the old adage, "an ounce of prevention is worth a pound of cure."

You are surely all aware that, in the world of medicine, for example, the philosophy of prevention is gaining ground. Through diet, exercise and other factors, physicians are seeking to prevent certain controllable diseases before they begin rather than devoting precious resources to conditions that could have been avoided in the first place. So, too, one of the main principles behind the amendments to this bill involves recognizing that prevention is the key to safety and health on the job site.

[*Translation*]

Now during the debate on this bill, you have heard various statistics dealing with sickness and injury in the workplace. They are worth repeating. In the federal jurisdiction, an average of 55,000 employees a year suffer job-related injuries or medical conditions. An average of 36 employees a year lose their lives in job-related accidents.

In New Brunswick, for example, an employee suffered a fatal fall from a roof he was inspecting. In Ontario, a crane operator died when the crane toppled over onto him. In Quebec, a dock employee was fatally crushed between two steel rolls during unloading operations. And the stories continue.

TÉMOIGNAGES

OTTAWA, le mardi 20 juin 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 17 h 03 pour faire l'examen du projet de loi C-12, Loi modifiant la partie II du Code canadien du travail portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquence.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Nos témoins, aujourd'hui, sont la ministre du Travail, l'honorable Claudette Bradshaw, et plusieurs de ses collaborateurs.

La ministre souffre d'une otite, et elle devra, pour cette raison, se rendre en voiture à Moncton ce soir, au lieu de prendre l'avion, pour rencontrer le premier ministre du Nouveau-Brunswick demain. J'espère que nous saurons être raisonnablement expéditifs avec nos questions.

Madame la ministre, je vous remercie d'avoir pris le temps de venir nous rencontrer. Je vous laisse la parole.

L'honorable Claudette Bradshaw, ministre du Travail: Avant de commencer, je tiens à vous remercier de votre compréhension et pour avoir accepté d'avancer notre rencontre à ce soir, au lieu de demain. Je vous en suis très reconnaissante.

Honourables sénateurs, je suis très heureuse de vous parler aujourd'hui du projet de loi C-12 modifiant la partie II du Code canadien du travail. Lorsque nous discuterons de ces modifications qui influenceront sur la santé et la sécurité des employés, il serait bon de nous rappeler qu'«il vaut mieux prévenir que guérir».

Vous savez tous certainement qu'en médecine, par exemple, on met de plus en plus l'accent sur la prévention. Avec les régimes alimentaires et l'exercice, entre autres, les médecins cherchent à prévenir certaines maladies avant qu'elles n'apparaissent, plutôt que de consacrer de précieuses ressources au traitement de maux qui auraient pu être évités. De même, l'un des principes fondamentaux des modifications du projet de loi est la reconnaissance que la prévention est la clé de la santé et de la sécurité au travail.

[*Français*]

Au cours du débat sur ce projet de loi, on vous a donné ou on vous donnera diverses statistiques sur les accidents et les maladies du travail. Il vaut la peine de les répéter. Dans la sphère de compétence fédérale, chaque année, en moyenne, environ 55 000 employés sont victimes d'accidents du travail ou de maladies professionnelles et 36 employés décèdent au travail.

Par exemple, au Nouveau-Brunswick, un employé s'est tué en tombant d'un toit qu'il inspectait. En Ontario, un conducteur de grue a été écrasé quand la grue qu'il conduisait s'est renversée sur lui. Au Québec, un débardeur a été coincé entre deux rouleaux d'acier pendant le déchargement d'un navire. Et je pourrais vous citer d'autres exemples.

Of course, the stories that involve loss of life are the most tragic, but there are countless others involving injuries and illnesses. In each case, whether fatal or non-fatal, many other people are affected — children, spouses, parents, friends and co-workers.

This is why Bill C-12 is before you today. All the changes we are proposing reflect the Government of Canada's desire to reduce and ultimately eliminate death, injury and illness in the workplace.

[English]

As you may know, this bill is the end product of countless hours of debate and discussion between government, labour and management. Hundreds of proposals were considered and consensus was reached on a substantial number of important initiatives. This speaks to the degree of cooperation brought about by the subject matter itself: When human lives are at stake, people are willing to put differences aside to work for the common good.

It is this spirit that is at the core of many of the changes we are proposing today. Prevention of accidents and illness in the workplace is best achieved through the awareness, and therefore the participation, of all employees.

There are several ways this new legislation will encourage increased awareness and participation in safety issues by employees.

First, this bill specifically states that employers must develop health and safety education and prevention programs in the workplace. As well, the existing health and safety committees will see their powers and duties greatly expanded so that, among other things, they cooperate with management to see that these programs are implemented and monitored.

Second, employers will be required to identify and assess employee exposure to hazardous substances. They will also have to share this information with the committee, who will then be able to act more quickly in assessing potential employee exposures to these substances. Similarly, the committees will be able to access all government and employer reports, studies and tests that have a bearing on workplace health and safety.

Furthermore, the creation of the new mandatory policy health and safety committees in workplaces with 300 or more employees will also emphasize prevention. This amendment will ensure that health and safety issues are addressed at the corporate level and that employers who may have job sites scattered over areas far and wide consistently deal with these issues.

[Translation]

One of the issues for which regulations may be developed — after consulting all the affected parties — is that of ergonomics, which is specifically listed in the amendments. We are all aware of the huge changes taking place in the world of work. The increase in automation and the use of computers has led to a greater impact on repetitive strain injuries such as carpal tunnel syndrome. As a result of these injuries, the science of ergonomics

Les accidents mortels sont les plus tragiques, mais il y en a des milliers d'autres dont les victimes gardent des séquelles. Chaque accident, mortel ou non, affecte plusieurs autres personnes, les enfants, le conjoint, les parents, les amis et les collègues.

D'où l'étude aujourd'hui du projet de loi C-12. Tous les changements que nous proposons s'inspirent du désir du gouvernement du Canada de réduire à zéro le nombre de décès, d'accidents et de maladies liés au travail.

[Traduction]

Vous savez peut-être que ce projet de loi est le fruit d'un nombre incalculable d'heures de discussion entre le gouvernement, les syndicats et les entreprises, au cours desquelles on a étudié des centaines de propositions et réalisé un consensus sur un bon nombre de propositions importantes. Cela montre bien que la nature du projet de loi à l'étude a nettement favorisé la coopération. En effet, quand des vies humaines sont en jeu, les gens sont prêts à mettre leurs divergences idéologiques de côté pour travailler pour le bien commun.

Bien des changements proposés aujourd'hui s'appuient sur cet esprit de collaboration, car la meilleure façon de prévenir les accidents et la maladie liés au travail est d'éduquer les employés et de les faire participer.

Ce nouveau projet de loi encouragera une plus grande prise de conscience de la part des employés et leur participation aux questions de santé et de sécurité.

Premièrement, il stipule que les employeurs devront élaborer des programmes de formation et de prévention en matière de santé et de sécurité au travail. Il élargit considérablement les pouvoirs et les obligations des comités de santé et de sécurité actuels, pour leur permettre, entre autres, de collaborer avec les employeurs à élaborer ces programmes et à en contrôler l'application.

Deuxièmement, les employeurs devront identifier et évaluer les substances dangereuses présentes dans le lieu de travail. Ils devront aussi partager l'information à ce sujet avec les comités, pour leur permettre d'évaluer plus rapidement le degré d'exposition des employés à ces substances. Les comités pourront aussi consulter les rapports, les études et les analyses de l'État et de l'employeur qui ont un rapport avec la santé et la sécurité au travail.

En outre, les employeurs qui ont 300 employés ou plus devront former des comités d'orientation en matière de santé et de sécurité, ce qui assurera encore mieux la prévention. Ainsi, les questions de santé et de sécurité seront traitées d'une façon plus uniforme dans les entreprises dont les installations ne sont pas concentrées en un seul endroit.

[Français]

Après consultation des parties intéressées, des règlements pourront être élaborés, entre autres, en matière d'ergonomie, comme le stipule les modifications. Nous sommes tous conscients des énormes changements qui se produisent dans le monde du travail. L'automatisation et la prolifération des ordinateurs favorisent les microtraumatismes répétés, comme le syndrome du tunnel carpien. La multiplication de ce genre d'accidents a attiré

has been in the spotlight as of late, even though it has existed for decades.

Another specific way in which it deals with prevention concerns the rights of pregnant and nursing mothers. The amendments will add a new section, independent of the right to refuse dangerous work, which will provide extra protection for these employees. Here is how it works.

Previously, there was no specific coverage for pregnant and nursing women under Part II of the code. When they thought that their job was dangerous to their health or to their foetus or breast-fed child, they had to wait until they could obtain a medical certificate, all the while possibly putting themselves, the foetus and their children at risk.

The current labour standard provisions of Part III of the Canada Labour Code offers a pregnant or nursing woman limited protection. She may request that her employer temporarily modify her job duties or reassign her to another job, where reasonably practicable. A physician's certificate indicating how long the risk is likely to last and what activities or conditions should be avoided, is required.

Under the proposed legislation, this woman can now withdraw from work she feels is potentially harmful — with full pay and benefits, until she consults with her doctor, as soon as possible, and her employer can reassign her to another safe job or location until then.

[English]

These are just examples of how the amendments to Bill C-12 will help prevent illness or injury. Of course, government health and safety officers will still inspect job sites, investigate violations and write directions for remedial action and, when all else fails, recommend prosecution and fines, which the bill proposes to significantly increase.

No matter how perfect the rules or system we put into effect, humans and the world in which they operate are not. That is why we have to keep a watchful eye. We can rigorously try to prevent, educate, supervise, monitor and test and we can significantly reduce illness and accidents in the workplace, as we have over the past 20 years. However, when all else fails, then we are prepared to hold those who are irresponsible accountable, as we have in the past, by sharply increasing fines for continuing failure, for instance, to comply with a health and safety officer's written direction.

Honourable senators, we welcome continued debate but hope for swift resolution of any differences we may have in the details. I know we all agree on the overriding principles of this bill because it will protect the lives of Canadian employees — a goal on which we all agree.

récemment l'attention sur l'ergonomie, même si cette science existe depuis des dizaines d'années.

Ce projet de loi favorise aussi la prévention en ce qui concerne les femmes enceintes et allaitantes. En effet, il ajoute au code un article indépendant des dispositions relatives au refus de travailler en cas de danger, qui leur assure une protection additionnelle. Voyons cet article de plus près.

Auparavant, il n'était pas question des femmes enceintes ou allaitantes dans la partie II du code. Alors, quand elles avaient des raisons de croire que leur travail pouvait nuire à leur santé ou à celle du foetus ou de l'enfant qu'elles allaitaient, elles devaient attendre d'obtenir un certificat médical, au risque de nuire entre-temps à sa santé ou à celle du foetus ou de l'enfant qu'elles allaitaient.

Les dispositions actuelles de la partie III du Code canadien du travail, qui porte sur les normes du travail, leur offre une protection limitée. Elle peuvent demander que leur employeur modifie leurs tâches ou leur en donne d'autres, si possible, pendant un certain temps. Elles doivent obtenir un certificat médical indiquant la durée de la période de risque et les activités ou les situations à éviter.

Aux termes du projet de loi, elle peuvent maintenant cesser d'effectuer une tâche qu'elles jugent risquée, ceci avec plein salaire et avantages, jusqu'à ce qu'elles aient consulté leur médecin, étant entendu qu'elles le feront le plus tôt possible. Leur employeur peut entre-temps les réaffecter à un autre travail ou endroit sécuritaires.

[Traduction]

Ce n'étaient là que quelques exemples de la façon dont les modifications proposées au projet de loi C-12 contribueront à prévenir la maladie et les accidents liés au travail. Évidemment, les agents de santé et de sécurité du gouvernement continueront d'inspecter les lieux de travail, d'enquêter sur les infractions, d'imposer des mesures correctrices aux contrevenants et, au besoin, de recommander des poursuites et des amendes dont le montant, en passant, sera considérablement augmenté.

Même si les règles ou les systèmes que nous mettons en place étaient parfaits, les êtres humains et le milieu dans lequel nous tous évoluons ne le sont pas. C'est pourquoi nous devons rester vigilants. Nous pouvons prendre des mesures rigoureuses pour prévenir, éduquer, superviser, contrôler et analyser. Nous pouvons réduire considérablement le nombre de maladies et d'accidents liés au travail, comme nous le faisons depuis 20 ans. Cependant, lorsque rien n'y fait, nous sommes prêts à punir les irresponsables, comme nous l'avons toujours fait, par exemple en augmentant considérablement les amendes pour ceux qui refusent systématiquement de se conformer aux instructions des agents de santé et de sécurité.

Honorables sénateurs, nous serions heureux de poursuivre les délibérations, mais nous espérons que les divergences de vues sur les questions de détail pourront être réglées rapidement. Je sais que nous sommes tous d'accord sur les principes fondamentaux de ce projet de loi, parce qu'il vise à protéger la vie des employés canadiens, à laquelle nous attachons tous le plus grand prix.

The Chairman: Before turning to Senator Kinsella to begin the questioning, I should like to ask one of your officials to deal with an issue on which there has been some confusion among members of the committee. The issue revolves around the response that your predecessor, Minister MacAulay, made on the issue of gender-neutral language in Part I at the time that the bill was before the committee some time ago. The confusion has been about whether or not that issue has been resolved. Could someone tell us the exact state with respect to that particular issue at the present time?

Ms Bradshaw: Mr. Gerry Blanchard will answer that for you, but before he does, I want to thank you for raising that Part I matter with us. As you will be able to see, the officials have done a lot of work to ensure that we remedied Part I so that you would not have it in Part II.

Mr. Gerry J. Blanchard, Director General, Labour Operations (DGO), Labour Program, National Headquarters, Human Resources Development Canada: First, Part II complies with all the gender-neutral standards. In Part I, it is true that specific language needed to be corrected to meet this objective. That was done by using the provisions included in the Miscellaneous Statute Law Amendment Act. On June 17, 1999, this received Royal Assent. This was done to correct the gender neutral aspect of Part I. There was, however, a drafting error to two of the subclauses, which led to the fact that the English version of this revision did not reflect the same as the French and still needed to be corrected. That is the part that is technically corrected in Part II of the code. It is only that section that needed to be corrected.

With the technical amendments that have been included in the tail end of this section, the bill will be completely gender-neutral — Parts I and II of the Canada Labour Code. It has been corrected.

The Chairman: Mr. MacAulay gave a commitment when he appeared before this committee on June 18, 1998, when he said, "I want to pursue this matter and I am actively exploring with my colleagues ways to accommodate these concerns without reopening discussions on the substance of Part I of the code." By "this matter," he means the gender-neutrality issue. He then went on to say, "I expect to introduce amendments to Part II of the code later this year, which could present an opportunity to address this issue." This is a couple of years later, but that is before us now. He then commented on it. You are saying that as a result of the Miscellaneous Statute Law Amendment Act that was passed into law a year ago, plus the changes that are here today, gender neutrality is in the entire act?

Mr. Blanchard: That is right. The Miscellaneous Statute Law Amendment Act was the instrument that was found to enable this to be done. There was a minor drafting error to two of the subclauses and that drafting error was caught in the technical amendments area.

Le président: Avant de laisser le sénateur Kinsella entamer la période de questions, j'aimerais demander à l'un de vos collaborateurs d'élucider un problème qui a suscité quelque confusion parmi les membres du comité. Cela concerne la réponse de votre prédécesseur, le ministre MacAulay, sur la question du langage non sexiste dans la partie I, à l'époque où le comité discutait du projet de loi, il y a quelque temps. Nous nous demandons encore si le problème a été résolu. Quelqu'un pourrait-il nous dire exactement où cela en est actuellement, à ce sujet particulier?

Mme Bradshaw: M. Gerry Blanchard pourra vous répondre, mais avant cela, je tiens à vous remercier d'avoir soulevé la question de la partie I avec nous. Comme vous pourrez le constater, mes collaborateurs ont beaucoup fait pour résoudre le problème de la partie I de manière à ce qu'il ne se répète pas dans la partie II.

M. Gerry J. Blanchard, directeur général, Opérations du travail, Programme du travail, Administration centrale, Développement des ressources humaines Canada: Tout d'abord, je tiens à préciser que la partie II est conforme à toutes les normes relatives au langage non sexiste. Dans la partie I, il est vrai qu'il fallait corriger des passages spécifiques pour pouvoir réaliser cet objectif. Cela a pu se faire en recourant aux dispositions que renferme la Loi corrective. Elle a reçu la sanction royale le 17 juin 1999. C'était dans le but de corriger le problème de langage sexiste à la Partie I. Cependant, une erreur de rédaction s'est glissée dans deux paragraphes, ce qui a fait que la version anglaise de cette révision ne disait pas la même chose que la version française, et il fallait encore apporter des corrections. C'est la partie qui, techniquement, est corrigée dans la partie II du code. Ce n'est que cette section qui avait besoin d'être corrigée.

Avec les amendements techniques qui ont été apportés à la fin de la section, le projet de loi sera intégralement rédigé en langage non sexiste — les parties I et II du Code canadien du travail. Tout a été corrigé.

Le président: Monsieur MacAulay a pris un engagement lorsqu'il a comparu devant le comité le 17 juin 1998, lorsqu'il a dit «Je veux explorer davantage ce point et je cherche, avec mes collègues, des façons d'adresser ce problème sans pour autant reprendre les discussions sur le fond de la Partie I du Code». Par «ce problème», on entend le problème du langage non sexiste. Il a ensuite ajouté: «Je prévois présenter les modifications à la partie II du Code plus tard cette année, ce qui me permettrait alors de traiter de ce point». Cela fait déjà deux ans, mais nous y voilà tout de même. Il a ensuite fait certaines observations à ce sujet. Ce que vous dites, c'est qu'avec la promulgation de la Loi corrective il y a un an et les changements qui sont devant nous aujourd'hui, l'ensemble de la loi respecte maintenant les règles du langage non sexiste?

M. Blanchard: C'est cela. La Loi corrective a été l'instrument qui nous a permis de réaliser cet objectif. Deux des paragraphes renfermaient une erreur de rédaction sans gravité, qui a été corrigée à l'occasion des amendements techniques.

The Chairman: I was confused, because I did not pick up the changes that had been made in the Miscellaneous Statute Law Amendments Act; they are not yet rewritten into the revised version of the code.

Mr. Blanchard: That is right. If you were looking at that part of the code, it has not been revised yet.

The Chairman: That is right. That is what I was doing.

Senator Kinsella: I wish to point out that you are in good company. There are five senators from New Brunswick around the table, namely, Senators Bryden, Robertson, Cohen, De Ware and myself. We in New Brunswick are very much aware of the fact that, by coming to a committee such as the Standing Senate Committee on Social Affairs, you are in a room where you could provide us with a great deal of leadership and instruction. We all are appreciative of the tremendous work that you have done in your community and continue to do now that you are part of the government.

I am pleased with that report from your officials. The office consolidation that I have is dated January 1, 1999.

The Chairman: That is what I had also. That is where I got confused.

Senator Kinsella: Perhaps we could be advised. Is there a new consolidation of the code? Are you telling us that the code now, throughout, is gender neutral?

Mr. Blanchard: The copies of Part II are all gender neutral. I am not a legal expert, but I understand that they will correct this. They do this periodically. However, in the meantime, Part I of the code still contains the gender reference, but it is nullified by the Miscellaneous Statute Law Amendment Act.

Senator Kinsella: One of the reasons that some of us were arguing and underscoring the importance of this code being written in gender-neutral language is that it is pedagogical. The Canada Labour Code is utilized, is it not, by every labour organization in the country under federal jurisdiction? Unlike other statutes that only lawyers look at, workers' organizations and their leadership have copies of this.

Will there be an office consolidation done that you will begin to distribute with the amendments that are contained in Bill C-12?

Ms Bradshaw: Yes. We will make sure that you get a copy as soon as it is available. Again, we want to thank you for bringing that to our attention.

Senator Kinsella: Minister, does your department also produce a digest or a version of the code that is a little more user-friendly? In other words, it is not the official legal statute but it is something that is in plain speak and in brochure form?

Senator DeWare: In layman's language?

Le président: J'étais embrouillé, parce que je n'ai pas vu les changements qui ont été apportés à la Loi corrective; ils n'ont pas encore été intégrés dans la version révisée du Code.

M. Blanchard: C'est vrai. Si c'est cette partie du Code que vous regardiez, elle n'a pas encore été révisée.

Le président: C'est bien vrai. C'est ce que je faisais.

Le sénateur Kinsella: J'aimerais vous faire remarquer que vous êtes en bonne compagnie. Il y a cinq sénateurs du Nouveau-Brunswick autour de la table, soit les sénateurs Bryden, Robertson, Cohen, DeWare et moi-même. Au Nouveau-Brunswick, nous sommes tout à fait conscients du fait qu'en vous présentant devant un comité comme le comité sénatorial permanent des affaires sociales, vous êtes en mesure de largement nous orienter et nous instruire. Nous apprécions tous le travail phénoménal que vous avez fait dans votre communauté et que vous continuez de faire, maintenant que vous faites partie du gouvernement.

Je suis satisfait du rapport qu'ont présenté vos collaborateurs. La codification administrative que j'ai est datée du 1^{er} janvier 1999.

Le président: C'est aussi ce que j'avais. C'est cela qui m'a embrouillé.

Le sénateur Kinsella: Peut-être pouvons-nous obtenir conseil. Est-ce qu'il y a une nouvelle codification administrative? Est-ce que ce que vous dites, c'est que le Code est maintenant, intégralement, rédigé dans un langage non sexiste?

M. Blanchard: Les exemplaires que vous avez de la partie II le sont. Je ne suis pas expert juridique, mais à ce que j'ai compris, ce sera corrigé. C'est fait périodiquement. Cependant, entre temps, la partie I du Code comporte toujours un langage sexiste, mais il est neutralisé par la Loi corrective.

Le sénateur Kinsella: L'une des raisons pour lesquelles nous n'étions pas d'accord et que nous soulignions l'importance de rédiger ce Code dans un langage non sexiste est son objectif pédagogique. Le Code canadien du travail est utilisé, n'est-ce pas, par toutes les organisations syndicales du pays qui relèvent de l'autorité fédérale? Au contraire d'autres lois que seuls les avocats consultent, les organisations syndicales et leurs dirigeants ont des exemplaires de ce document.

Est-ce qu'une codification administrative sera rédigée, que vous commencerez à distribuer avec les amendements au projet de loi C-12?

Mme Bradshaw: Oui. Nous veillerons à ce que vous en ayez un exemplaire dès qu'il sera disponible. Encore une fois, je tiens à vous remercier d'avoir porté cela à notre attention.

Le sénateur Kinsella: Madame la ministre, est-ce que votre ministère produit aussi un condensé du Code, ou une version dont le langage soit un peu plus convivial? Autrement dit, un document qui n'est pas le document légal officiel, mais quelque chose de plus simple, sous forme de brochure?

Le sénateur DeWare: En langage non-spécialiste?

Senator Kinsella: Does the department have that kind of thing?

Mr. Warren Edmonson, Assistant Deputy Minister, Labour Program, National Headquarters, Human Resources Development Canada: We do produce some more user-friendly documents to help people involved in the administration of Part II of the Canada Labour Code. With these amendments, however, we will have to revisit our tool kit to ensure that all the amendments contained in this bill would be included in a new program.

If we have the resources available — and I hope we can find them, somewhere — we hope to do a road show across the country for our labour-management partners out there, to explain to them the provisions of this bill and the intentions, in particular, of the amendments, so that they understand what we are trying to achieve.

Senator Kinsella: Approximately how many boards or commissions or committees do you have to appoint under the labour code? There are quite a few, are there not?

Mr. Edmonson: I would say half a dozen.

Senator Kinsella: The big one being?

Ms Bradshaw: Yes, the Canada Labour Relations Board.

Senator Kinsella: Under this proposed act, there is a board that focuses on industrial safety. Could we have sent to the committee a list of all those boards, with the names of the persons who have been appointed to those boards and the length of their tenure?

Ms Bradshaw: We can provide you with that.

Senator Robertson: Thank you, minister, for coming here this afternoon. I wish to ask you a few questions about workplace violence. As I understand it, although the parties involved in the consultation process concluded that the bill should include a regulation on a workplace violence prevention program, my colleague Senator DeWare pointed out in her speech that the bill does not explicitly do that. As well, I am informed that the bill does not go as far as provisions found in the legislation in Saskatchewan and British Columbia. All around this table, we have heard stories and read news reports about serious workplace violence; for example, the unfortunate shooting at a bus garage here in Ottawa comes to mind immediately. I call it the schoolyard bully syndrome. Every once in a while, you have someone who is continually ridiculing or being rude or mean or unkind because of race or colour or handicap. There is no teacher to advise about the pent-up tensions. As we know, sometimes, this ends up in a violent situation.

Le sénateur Kinsella: Est-ce que le ministère produit ce genre de document?

M. Warren Edmonson, sous-ministre adjoint, Programme du travail, Administration centrale, Développement des ressources humaines Canada: Nous produisons effectivement des documents en langage plus convivial pour aider les gens qui participent à l'administration de la partie II du Code canadien du travail. Avec ces amendements, cependant, nous devons revoir le contenu de notre trousse d'outils pour nous assurer que tous les amendements que renferme ce projet de loi sont intégrés à un nouveau programme.

Si nous avons les ressources nécessaires — et j'espère que nous les trouverons, quelque part — nous voudrions pouvoir faire une tournée de présentation dans tout le pays à l'intention de nos partenaires patronaux et syndicaux, pour leur expliquer les dispositions de ce projet de loi et les objectifs, en particulier, des amendements, pour qu'ils puissent comprendre ce que nous espérons réaliser.

Le sénateur Kinsella: Environ combien de conseils, de commissions ou de comités devez-vous mettre sur pied, en vertu du Code canadien du travail? Il y en a pas mal, n'est-ce pas?

M. Edmonson: Je dirais environ une demi-douzaine.

Le sénateur Kinsella: Le plus important étant...

Mme Bradshaw: La Commission des relations de travail du Canada.

Le sénateur Kinsella: En vertu de la loi qui est proposée, une commission doit se consacrer à la sécurité au travail. Le comité aurait-il pu recevoir une liste de toutes ces commissions, avec les noms des personnes qui y siègent et la durée de leur mandat?

Mme Bradshaw: Nous pouvons vous la fournir.

Le sénateur Robertson: Merci, madame la ministre, d'être venue cet après-midi. J'aimerais vous poser quelques questions sur la violence dans le milieu de travail. À ce que je comprends, bien que les participants au processus de consultation sont arrivés à la conclusion que le projet de loi devrait renfermer un règlement visant un programme de prévention de la violence dans le milieu de travail, ma collègue, le sénateur DeWare, a fait remarquer dans son allocution que le projet de loi ne contient rien d'explicite à cet effet. De plus, j'apprends que le projet de loi n'est pas aussi ferme que certaines dispositions que contiennent les lois de la Saskatchewan et de la Colombie-Britannique. Nous tous, ici, avons entendu des histoires et lu des articles dans les journaux sur des incidents graves de violence dans le milieu de travail; pour vous donner un exemple, la malheureuse fusillade dans un garage d'autobus ici, à Ottawa, nous vient immédiatement à l'esprit. J'appelle cela le syndrome du fier-à-bras de la cours d'école. De temps en temps, il y a quelqu'un pour constamment ridiculiser quelqu'un d'autre, être grossier, méchant ou cruel à son égard sous prétexte de sa race, de sa couleur ou d'un handicap. Les professeurs n'enseignent rien sur les tensions accumulées. Nous le savons, parfois, elles mènent à des situations de violence.

Could you help me understand the nature and the magnitude of the problem in Canada? Although this bill covers federal jurisdiction only, how serious is workplace violence in Canada?

I have several questions. Perhaps I will go through them all and then you can answer them all at once.

Minister, can you provide me with statistics to help me understand the problem? What are the most common kinds of offences in the workplace? I am sure you have statistical evidence about this sort of thing. Is it disgruntled employees going after their bosses, or the meanness to which I referred? What is it? Is any one industry more prone to workplace violence than another? How do these instances of violence in the workplace end up? Do they go before the courts? What usually happens? Is there a problem of not reporting?

Do you feel that the workplace violence provisions in the bill go far enough or are good enough to carry well into the future? We all know that the labour code is opened up infrequently. We also know that some jurisdictions are ahead of the government. Who knows when we will open it up again. I should like some answers to my concerns and to my questions, if you have that information, because I do not know how you will tighten it up unless it is put into this legislation, or when it will be tightened up. It does not happen every year or two that we upgrade this legislation. Those are my general remarks and questions and concerns.

Ms Bradshaw: You and Senator DeWare certainly know the work that I have done and the feeling that I have towards violence anywhere. Having said that, one of the unique opportunities that we have, as Minister of Labour and in the program of labour, is that almost everything we do is tripartite. It is always with the employee and the employer's group. I can assure you that we have a working group put together now on prevention and violence. They are putting regulations into place.

Normally, this process can take an average of about three years, if they have the statistics. If they do not have them, then we must find the statistics. That is why it is interesting to work with both the labour movement and the employers, because it is a real education for all of us. We sit at the table with them.

I cannot say to you that we specifically have statistics on the questions that you are asking. However, I know that CLC has done a lot of research on that. Possibly, we could get you some of their statistics. That is why we have them sitting at the table with us doing the regulations. Also, that is why we have the employer and ourselves sitting at the table for the regulations on violence and prevention. In the near future, we hope to put a working group together on the new issue of ergonomics. I can assure you that the group is already working on the regulation.

Pourriez-vous m'aider à comprendre la nature et l'envergure du problème au Canada? Même si ce projet de loi ne relève que de l'autorité fédérale, quel est le degré de gravité de la violence dans le milieu de travail au Canada?

J'ai plusieurs questions à vous poser. Peut-être devrais-je les poser, puis vous pourrez répondre à toutes ensemble.

Madame la ministre, pourriez-vous me fournir des statistiques qui m'aideraient à comprendre la portée du problème? Quelles sont les infractions les plus courantes dans le milieu de travail? Je ne doute pas que vous ayez des statistiques sur ce genre de choses. Est-ce que ce sont les employés mécontents qui s'attaquent à leurs patrons, ou le genre de cruautés dont j'ai parlé? Qu'est-ce que c'est? Est-ce qu'il y a un secteur de l'industrie qui est, plus que les autres, sujet à la violence dans le milieu de travail? Comment finissent ces situations de violence? Est-ce que c'est devant les tribunaux? Qu'est-ce qui se passe en général? Est-ce qu'il y a un problème de manque de signalement de ces situations?

Estimez-vous que les dispositions relatives à la violence dans le milieu de travail que comporte le projet de loi vont assez loin ou sont suffisantes pour bien subir le passage du temps? Nous savons tous que le Code du travail n'est pas souvent reformulé. Nous savons aussi que certaines administrations ont de l'avance sur le gouvernement. Qui sait quand le code sera réouvert? J'aimerais avoir des réponses à mes préoccupations et à mes questions, si vous avez cette information, parce que je ne sais pas comment vous pourrez renforcer les mesures sans les prévoir dans la loi, ou encore quand cette loi pourra être raffermie. Ce n'est pas tous les ans ou tous les deux ans que nous mettons cette loi au point. C'est tout pour mes observations générales, mes questions et mes préoccupations.

Mme Bradshaw: Le sénateur DeWare et vous-même savez certainement le travail que j'ai fait et ce que je pense de la violence, quelle qu'elle soit. Ceci dit, l'une des possibilités uniques que nous avons, en tant que ministre du Travail et dans le cadre du programme du travail, c'est que presque tout ce que nous faisons, nous le faisons à trois, c'est-à-dire toujours avec le groupe des employés et employeurs. Je peux vous assurer que nous avons un groupe de travail qui travaille maintenant sur la prévention et la violence. Il est en train de formuler des règlements.

Normalement, ce processus prend environ trois ans, lorsqu'on a des statistiques. Si on n'en a pas, il faut les trouver. C'est pourquoi il est intéressant de travailler avec le mouvement syndical et les employeurs, parce que c'est très éducatif pour tout le monde. Nous discutons avec eux.

Je ne peux pas vous dire si nous avons des statistiques, particulièrement, sur les sujets dont vous avez parlés. Par contre, je sais que le CTC a fait beaucoup de recherches là-dessus. Peut-être pourrions-nous obtenir leurs statistiques pour vous. C'est pourquoi nous les avons invités à participer avec nous à la formulation des règlements. C'est aussi pourquoi l'employeur et nous-mêmes participons aux discussions sur les règlements relativement à la violence et à la prévention. Nous espérons très bientôt créer un groupe de travail sur la nouvelle question des l'ergonomie. Je peux vous assurer que le groupe travaille déjà sur la réglementation.

Senator Robertson: When you have those regulations, would you make copies available to us at the earliest opportunity?

Ms Bradshaw: We certainly will. The other information I can give you on health and safety is that we are celebrating our 100th anniversary this year. In September, we will have a conference with our youth. It is important for us, on this our 100th anniversary, to bring our youth together. We have done work with the unions and the employers, but we feel strongly that we should bring youth together on these issues of health and safety, their rights, violence in the workplace, and the prevention of violence in the workplace. We will also be looking at bringing youth in at that conference and discussing these issues with them.

Senator Robertson: Are those people in the workplace?

Ms Bradshaw: Yes.

Senator Robertson: Have you figured out the age group yet?

Ms Bradshaw: We are still working on it.

Mr. Edmonson: About 18 years old.

Ms Bradshaw: It is important that we start working with our young people so that they know about this. It will probably be about 18 years old.

Senator Robertson: I am glad you are doing that. I always think the federal government should lead and not be behind the provinces.

Senator DeWare: Madam Minister, I should like to compliment you on the bill. It is well done. New Brunswick had the privilege of appointing the first commission on health and safety between 1978 and 1980. At the time, we had to go through what you are going through to make sure about safety. I am familiar with what you are trying to do here. I am aware of the importance of safety in the workplace. I can remember travelling around the province when we had to check all the companies, such as Irving, the shipyards, and so on. After a while, some of them had a plaque on their wall saying, "121 accident-free days" and how proud they would be of that and how important it became to the employees in those companies to have an accident-free day. That is something you might want to try to promote some time.

First, you have committees that have been established in the workplace. You have an appeals officer, a health and safety officer, health and safety representatives, a policy committee, and a regional health and safety officer. You have given them a lot of latitude in this bill to do their job, which is important, too. You cannot do your job unless you put teeth in it and allow them to do that. Time lost is income lost, both for the employee and for the employer, and health-wise as well.

Le sénateur Robertson: Pourriez-vous nous fournir des exemplaires de cette réglementation dès qu'elle sera prête?

Mme Bradshaw: Certainement. Il y a autre chose, au sujet de la santé et de la sécurité; nous célébrons notre centenaire cette année. En septembre, nous organisons une conférence pour nos jeunes. Nous trouvons important, à l'occasion de notre centième anniversaire, d'unir nos jeunes. Nous avons travaillé avec les syndicats et les employeurs, mais nous croyons fermement qu'il nous faut unir les jeunes et les renseigner sur les questions de santé et de sécurité, sur leurs droits, sur la violence et la prévention de la violence dans le milieu de travail. Nous essaierons de faire participer des jeunes à cette conférence, pour discuter de ces questions avec eux.

Le sénateur Robertson: Est-ce que ce sont des jeunes en milieu de travail?

Mme Bradshaw: Oui.

Le sénateur Robertson: Avez-vous déjà déterminé le groupe d'âge visé?

Mme Bradshaw: Nous en discutons encore.

M. Edmonson: Ce serait les jeunes d'environ 18 ans.

Mme Bradshaw: Il importe que nous commençons à travailler avec nos jeunes pour qu'ils soient au courant de tout cela. Ils seront probablement âgés d'environ 18 ans.

Le sénateur Robertson: Je suis heureuse que vous le fassiez. Je suis toujours d'avis que le gouvernement fédéral devrait être à l'avant-garde plutôt qu'à la traîne des provinces.

Le sénateur DeWare: Madame le ministre, je tiens à vous complimenter pour le projet de loi. Il est très bien fait. Le Nouveau-Brunswick a eu le privilège d'être la première à mettre sur pied une commission de la santé et la sécurité, entre 1978 et 1980. À l'époque, il nous a fallu faire les démarches que vous faites maintenant pour être sûrs de ce que nous faisons en matière de sécurité. Je reconnais le but que vous visez. Je suis consciente de l'importance de la sécurité dans le milieu de travail. Je me rappelle avoir sillonné la province pour vérifier toutes les compagnies, comme Irving, les chantiers navals, et tout cela. Après un bout de temps, certaines affichaient une plaque où on pouvait lire «121 jours sans accident», qui montrait l'orgueil qu'elles en tiraient et l'importance qu'a acquis aux yeux des employés de ces compagnies le fait de passer toute une journée sans qu'il y ait d'accident. Peut-être devriez-vous faire le même genre de promotion un de ces jours.

D'abord, il y a les comités qui ont été créés dans le milieu de travail. Vous avez un agent des appels, et aussi un agent de la santé et de la sécurité, des représentants de la santé et de la sécurité, un comité chargé des politiques et un agent régional de la santé et de la sécurité. Vous leur avez donné, avec ce projet de loi, beaucoup de latitude pour s'acquitter de leurs fonctions, ce qui est important, aussi. On ne peut pas faire son travail si on n'a pas de mordant, et ce projet de loi leur en a donné. Le temps perdu, ce sont des revenus perdus, tant pour l'employé que pour l'employeur, et aussi sur le plan de la santé.

I was interested in your ergonomics as well and I wondered how far you had gone with that. The Americans established, in 1999, a wide-ranging proposal in this area. This will all come about through regulation, will it? How soon do you think you will be able to have some of that in place?

Ms Bradshaw: We are looking at a working group now. We want to do a lot of consultation on that. We know that regulations need to be put in place. Rest assured that we will be working on it.

Senator DeWare: Your medical people in workmen's compensation can certainly give you a big hand in that because it is difficult in the workplace to decide who's got a backache and who does not, and why. It is very difficult.

Ms Bradshaw: I cannot give you a timeline now because there are many consultations that we will have to make before we put the working group together. As soon as our consultations are finished, we will be putting the working group together and coming up with the regulations.

Senator DeWare: This arose from your consultation group. Was it quite highly discussed?

Ms Bradshaw: You can imagine that the labour movement is quite anxious for us to put a working group together as soon as possible.

Senator DeWare: I appreciate the effort that has gone into this. I also notice that your fines are quite hefty, but if you do that, then you will ensure that companies will comply with the safety rules.

Ms Bradshaw: When we speak about health and safety, last year in this country we lost \$10 billion. Often, when we speak about health and safety, the public feels that it is another union issue. That is not the case here. Here, the employer wants to see health and safety issues in the workplace put in place as much as the employees do. In a country like ours, when you speak about \$10 billion, that also affects the employer.

Senator DeWare: I appreciate the effort that you have put into this. I will look forward to you coming up with the information that the committee has requested.

[Translation]

Senator Pépin: On reading the bill, we note that it provides special protection for pregnant and nursing women. It states that they must consult with their physician, who is generally an obstetrician. Who chooses the physician? The employer? The committee perhaps?

Furthermore, we know that obstetricians are knowledgeable about workplaces, but they are not experts. Will they be required to consult someone and should extensive knowledge of the workplace be a prerequisite?

Ms Bradshaw: The employee chooses the doctor, not the employer. Her doctor is familiar with her condition.

J'ai trouvé intéressant de vous entendre parler d'ergonomie, aussi, et je me demande où vous en êtes dans le domaine. Les Américains ont déposé, en 1999, une proposition à grande échelle à ce sujet. Tout cela se fera avec la réglementation, n'est-ce pas? Quand pensez-vous, au plus tôt, être en mesure de commencer à mettre ces mesures en oeuvre?

Mme Bradshaw: Nous envisageons en ce moment de mettre sur pied un groupe de travail. Nous voulons largement consulter sur la question. Nous savons qu'il faut une réglementation. Soyez assurée que nous y travaillons.

Le sénateur DeWare: Le personnel médical de votre service d'indemnisation des travailleurs peut certainement vous donner un gros coup de main là-dessus, parce qu'il est difficile de déterminer, dans un milieu de travail, qui a un mal de dos et qui n'en a pas, et pourquoi. C'est très difficile.

Mme Bradshaw: Je ne peux pas encore vous parler d'échéancier, parce que de nombreuses consultations devront avoir lieu avant que nous puissions créer le groupe de travail. Dès que nos consultations seront terminées, nous mettrons un groupe de travail sur pied et nous formulerons les règlements.

Le sénateur DeWare: C'est ressorti des discussions de votre groupe de consultation. Est-ce qu'il en a beaucoup été discuté?

Mme Bradshaw: Vous pouvez imaginer que le mouvement syndical est très pressé de nous voir créer le groupe de travail.

Le sénateur DeWare: J'apprécie les efforts qui ont été déployés dans le domaine. Je remarque aussi que vos amendes sont assez lourdes, mais ainsi, vous vous assurez que les compagnies observeront les règles de sécurité.

Mme Bradshaw: Rien que du côté de la santé et de la sécurité, le Canada a perdu 10 milliards de dollars l'année dernière. Souvent, lorsqu'il est question de santé et de sécurité, le public a l'impression que c'est un autre problème qui relève des syndicats. Ce n'est pas le cas. Ici, l'employeur tient tout autant que l'employé à la santé et à la sécurité dans le milieu de travail. Dans un pays comme le nôtre, 10 milliards de dollars, cela touche aussi l'employeur.

Le sénateur DeWare: Je suis heureuse des efforts que vous avez déployés. Je suis impatiente de recevoir l'information que le comité a demandée.

[Français]

Le sénateur Pépin: Lorsqu'on lit le projet de loi, on constate qu'il y a une protection spéciale pour les femmes enceintes et celles qui allaitent leur enfant. On dit qu'elles doivent consulter leur médecin, qui est généralement un obstétricien. Qui va désigner le médecin? Est-ce l'employeur? Est-ce le comité?

Également, on sait que les obstétriciens connaissent les milieux de travail, mais ils n'en sont pas des spécialistes. Est-ce qu'on les obligera à consulter quelqu'un et est-ce qu'on devrait exiger qu'ils aient une connaissance importante du milieu de travail?

Mme Bradshaw: C'est l'employée qui va choisir le médecin, ce n'est pas son employeur. Son médecin connaît sa condition.

Senator Pépin: Nevertheless, the doctor needs to be familiar with the woman's workplace?

Ms Bradshaw: Her doctor can refer her to a specialist. However, it can be her own physician.

Senator Pépin: I will gladly play devil's advocate. Assuming a pregnant or nursing woman needs to consult her doctor to determine if she is at risk, what happens if she fails to do that and subsequently has a problem with her baby? Who is responsible?

Ms Bradshaw: That is one of the reasons why she may consult her own doctor. Normally, pregnant or nursing women have a doctor.

Senator Pépin: Fine. Mention is made in the bill of violence in the workplace. I believe two provinces, namely Saskatchewan and British Columbia, already have this kind of legislation on the books. The federal government is not proposing any changes in this area in Part II of the Canada Labour Code. Is this not an opportunity to try and broaden the scope of the bill and follow the lead of these two provinces?

Ms Bradshaw: Each province has its own legislation. As a federal minister, it is my responsibility to bring in legislation that applies from coast to coast.

Senator Pépin: This is a sound piece of legislation. I do have one brief comment. Earlier, someone asked for a list of the boards established under the Labour Code. All I hope is that as many women as men serve on these boards. This bill is also good for women out in the workforce. My wish is that one day, similar legislation will provide for day cares in the workplace.

Ms Bradshaw: In due time, Senator Pépin.

Senator Pépin: Yes indeed.

[English]

The Chairman: In closing, I wish to ask you one question that is not related to the bill but is an issue that has concerned me, and your officials may want to comment on it.

Particularly in the U.S., one notices a growing movement towards compulsory alcohol and drug testing for employees in positions that are regarded as dangerous. I think of the requirements that now exist in the U.S. with respect to truck drivers doing long-distance trucking, people working in nuclear power plants, and so on. To the best of my knowledge, I have not seen the development of that kind of public policy in Canada because we have had a tendency to move much more in the privacy direction and regard compulsory testing as "not acceptable in Canada." Is that an issue? Is there a policy coming down the road on that? Can you tell me roughly where that stands?

Ms Bradshaw: In Canada, you have the Charter of Rights.

Le sénateur Pépin: Cette personne doit tout de même connaître le milieu dans lequel elle travaille?

Mme Bradshaw: Si son médecin le désire, il peut la référer à un spécialiste. Cependant, cela peut être son propre médecin.

Le sénateur Pépin: Je veux bien me faire l'avocat du diable. On dit que la femme enceinte ou qui allaite doit consulter son médecin pour déterminer s'il y a un risque. Cependant, qu'arrive-t-il si elle manque à cette obligation et qu'elle a un problème avec son bébé? Est-ce elle qui en portera la responsabilité?

Mme Bradshaw: C'est une des raisons pour lesquelles on dit qu'elle pourrait consulter son propre médecin. Habituellement, les femmes enceintes ou qui allaitent ont un médecin.

Le sénateur Pépin: Parfait. Dans le projet de loi, on parle de la violence en milieu de travail. Je pense qu'il y a une ou deux provinces, soit la Saskatchewan et la Colombie-Britannique, qui ont déjà une loi à cet égard. Au niveau du gouvernement fédéral, je pense que ce n'est pas modifié dans la partie II du Code canadien du travail. Ne pourrait-on pas profiter de l'occasion pour essayer d'élargir la portée du projet de loi et prendre l'exemple de ces deux provinces?

Mme Bradshaw: Chacune des provinces a sa propre loi. En tant que ministre fédéral, il faut mettre des lois en place pour tout le pays.

Le sénateur Pépin: C'est un bon projet de loi. Je me permets aussi un petit commentaire. Quelqu'un a demandé plus tôt d'avoir la liste des bureaux de direction. Tout ce que j'espère, c'est qu'il y a autant de femmes que d'hommes qui siègent sur ces bureaux de direction. Également, ce projet de loi est bon pour les femmes qui vont travailler. Je fais un vœu, c'est qu'un jour un projet de loi semblable considère des garderies en milieu de travail.

Mme Bradshaw: Donnez-nous le temps, sénateur Pépin.

Le sénateur Pépin: Oui, je suis d'accord.

[Traduction]

Le président: Pour terminer, j'aimerais vous poser une question qui ne se rapporte pas au projet de loi, mais qui me préoccupe, et peut-être vos collaborateurs auront-ils des observations à formuler à ce sujet.

L'on constate, particulièrement aux États-Unis, une tendance croissante à obliger les employés qui occupent des postes jugés dangereux à subir des tests de dépistage de la consommation de drogue et d'alcool. Je crois que c'est l'une des obligations imposées maintenant aux États-Unis aux chauffeurs de camion sur de longues distances, aux employés des centrales nucléaires, et cetera. Jusqu'ici, je n'ai constaté aucune tendance favorable à ce genre de politique publique au Canada, parce que nous sommes portés à beaucoup plus protéger la vie privée et à considérer les tests obligatoires comme une chose «inacceptable au Canada». Est-ce qu'il en est question? Entrevoit-on d'avoir ce genre de politique ici? Pourriez-vous nous dire un peu ce qui en est?

Mme Bradshaw: Au Canada, il y a la Charte des droits et libertés.

The Chairman: That is right, but has there been jurisprudence that says that compulsory testing for certain occupations that were deemed to be in the interests of public safety is illegal?

Ms Bradshaw: Everything we do in the program of labour is with the employee and the employers. When the employee and the employers sit down and discuss a collective agreement, for example, if it were an issue, it certainly could be put in place.

Mr. Edmonson: I believe that the advice that we have been receiving from Justice to date is that there are Charter implications involved in this.

The Chairman: In the U.S., there has been a lot of movement in that direction. I did not understand if it was a Charter-based issue or whether there was another reason for not doing it.

Mr. Edmonson: There was an issue in Transport Canada a few years ago. Not only was there an unwillingness on the part of certain employees to engage in such practices, and even some employers, but there were Charter implications. That might be another reason the issue did not have legs.

Senator DeWare: Senator Kinsella asked me to tell you that they looked at your Web site on Part I and he feels that the old Web site is still not gender-specific-friendly and that you must change it after you get the bill in place.

Ms Bradshaw: We agree wholeheartedly. We will do that.

The Chairman: Minister, thank you and your officials for coming here.

Ms Bradshaw: I am not meeting the premier tomorrow but on Thursday. I wanted to state that on the record.

The Chairman: Thank you.

The committee adjourned.

Le président: C'est juste, mais y a-t-il une théorie générale de droit selon laquelle, dans certains métiers, les tests obligatoires qui sont jugés de l'intérêt de la sécurité publique sont illégaux?

Mme Bradshaw: Tout ce que nous faisons, dans le programme syndical, nous le faisons avec les employés et les employeurs. Quand ils s'assoient ensemble pour négocier une convention collective, par exemple, si c'est un sujet de préoccupation, il y aurait certainement moyen de mettre quelque chose en place.

M. Edmonson: Il me semble que ce que nous a dit le ministère de la Justice jusqu'ici, c'est que la Charte y intervient.

Le président: Aux États-Unis, c'est de plus en plus répandu. Je n'ai pas compris si le problème venait de la Charte ou s'il y a d'autres motifs qui s'y opposent.

M. Edmonson: Il y avait un problème avec Transports Canada il y a quelques années. Non seulement certains employés ne tenaient-ils pas à commencer ce genre de pratiques, et même aussi certains employeurs, mais il y avait les obstacles que posait la Charte. Cela pourrait expliquer encore pourquoi la question n'est pas allée plus loin.

Le sénateur DeWare: Le sénateur Kinsella m'a demandé de vous dire qu'il a examiné votre site Web, sur la partie I, qu'il trouve que l'ancien site Web n'est toujours pas rédigé en langage non sexiste et qu'il vous faudra le changer quand la loi sera entrée en vigueur.

Mme Bradshaw: Nous sommes tout à fait d'accord avec cela. Nous le ferons.

Le président: Madame la ministre, je vous remercie, ainsi que vos collaborateurs, d'être venus.

Mme Bradshaw: Je ne rencontre pas le premier ministre demain, mais jeudi. Je voulais le préciser aux fins du compte rendu.

Le président: Je vous remercie.

La séance est levée.

OTTAWA, Wednesday, June 21, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill C-12, to amend the Canada Labour Code (Part II) in respect of occupational health and safety, to make technical amendments to the Canada Labour Code (Part I) and to make consequential amendments to other acts; and Bill S-5, to amend the Parliament of Canada Act (Parliamentary Poet Laureate), met this day at 3:40 p.m. to give consideration to the bills.

Senator Michael Kirby (*Chairman*) in the Chair.

OTTAWA, le mercredi 21 juin 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie, auquel a été renvoyé le projet de loi C-12, Loi modifiant la partie II du Code canadien du travail, portant sur la santé et la sécurité au travail, apportant des modifications matérielles à la partie I du Code canadien du travail et modifiant d'autres lois en conséquence, ainsi que le projet de loi S-5, Loi modifiant la Loi sur le Parlement du Canada (poète officiel du Parlement), se réunit aujourd'hui, à 15 h 40, pour étudier la teneur des projets de loi.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[English]

The Chairman: Honourable senators, we are here to continue consideration of Bill C-12, to amend Part II of the Canada Labour Code and to make consequential amendments to other acts.

We have a panel of witnesses from both the labour union movement and from Federally Regulated Employers — Transportation and Communications.

The initial opening statement will be made by Mr. Hassan Yussuff, Executive Vice-President of the Canadian Labour Congress.

We have Mr. Jeff Bennie from the Canadian Union of Postal Workers and Mr. Denis St-Jean from the Public Service Alliance of Canada. We also have Mr. Don Brazier, Executive Director of Federally Regulated Employers — Transportation and Communications.

Mr. Hassan Yussuff, Executive Vice-President, Canadian Labour Congress: I want to thank honourable senators for allowing us the opportunity to come here to speak to this issue.

As you know, the Canadian Labour Congress represents about 2.3 million workers across the country. There are 1.1 million workers within the federal public sector. It is the fourth largest work-based jurisdiction in the country. This piece of proposed legislation will, of course, affect many workers across the country.

We want to congratulate the minister responsible for the file for moving this through the House and bringing it before the Senate.

In addition, we also want to state that we are hoping that, as a result of our appearance, and the minister's yesterday, the Senate will make this a priority and that the bill will be passed as quickly as possible.

This bill certainly does not make the federal government a leader, but it brings them close to being a leader in health and safety protection for workers on the job.

We have been engaged in a long and exhaustive process. There have been over six years of tripartite work with the labour movement, the employer, and of course the government through HRDC, to try to reach consensus on many items.

The vast majority of items laid out in this bill have been agreed to through a consensus process.

Where there was no consensus, the government made the unilateral decision to put forth positions with which we concur and that both parties support.

We support the bill. As we said before the Commons committee, and are saying again here, we do have concerns in a number of areas, including the appeals procedure, reassignment of pregnant workers, and extended rights of parliamentary workers. Despite those concerns, we want to say categorically that we support the quick passage of this bill.

This bill will bring protection for workers within the federal sector up to the appropriate standard, but most importantly, it will provide regulations in certain necessary areas on which we will

[Traduction]

Le président: Honorables sénateurs, nous allons poursuivre l'étude du projet de loi C-12, Loi modifiant la partie II du Code canadien du travail et modifiant d'autres lois en conséquence.

Nous accueillons aujourd'hui des représentants du mouvement syndical et des Employeurs des transports et communications de régie fédérale.

C'est M. Hassan Yussuff, vice-président directeur du Congrès du travail du Canada qui prendra d'abord la parole.

Nous recevons également M. Jeff Bennie, qui représente le Syndicat des travailleurs et travailleuses des postes du Canada, M. Denis St-Jean, qui représente l'Alliance de la fonction publique du Canada, ainsi que M. Don Brazier, directeur des Employeurs des transports et communications de régie fédérale.

M. Hassan Yussuff, vice-président directeur, Congrès du travail du Canada: Je tiens à remercier les honorables sénateurs de nous offrir l'occasion de venir leur exposer notre point de vue sur ce sujet aujourd'hui.

Comme vous le savez, le Congrès du travail du Canada représente environ 2,3 millions de travailleurs et travailleuses dans l'ensemble du pays. Le secteur public fédéral regroupe 1,1 million de travailleurs, ce qui en fait le quatrième plus important employeur du pays. Le projet de loi à l'étude va bien sûr toucher beaucoup de travailleurs au Canada.

Nous voulons féliciter la ministre responsable du dossier d'avoir présenté le projet de loi à la Chambre et au Sénat.

Nous espérons également que, dans la foulée de notre témoignage et de celui de la ministre hier, le Sénat fera de cette question une priorité afin que le projet de loi soit adopté le plus rapidement possible.

Avec ce projet de loi, le gouvernement fédéral ne devient certes pas un leader en matière de santé et de sécurité au travail mais presque.

Nous avons participé à un long et vaste processus. Pendant six ans, le mouvement syndical, le monde des affaires et, bien sûr, le gouvernement, par l'entremise de DRHC, ont collaboré pour essayer d'en arriver à un consensus sur bien des sujets.

La grande majorité des questions traitées dans le projet de loi ont fait l'objet d'un consensus.

Là où un consensus n'a pas été atteint, le gouvernement a pris des décisions unilatérales que nous acceptons, et que les deux parties approuvent.

Nous sommes d'accord avec le projet de loi. Comme nous l'avons dit devant le comité de la Chambre des communes, certaines questions nous préoccupent, notamment la procédure d'appel, l'affectation des travailleuses enceintes et la protection des travailleurs du Parlement. Malgré ces inquiétudes, nous tenons à dire que nous approuvons entièrement l'adoption rapide du projet de loi.

Le projet de loi accordera aux travailleurs du secteur public fédéral la protection voulue, mais surtout il permettra d'adopter des règlements nécessaires, ce sur quoi nous reviendrons un peu

comment a little later. The minister commented on the bill yesterday, and we will certainly respond to senators' questions after our presentation.

On behalf of the congress and our colleagues, we thank you for the opportunity to present our views. We look forward to your questions.

Mr. Don Brazier, Executive Director, Federally Regulated Employers — Transportation and Communications: I notice that Mr. Yussuff did not read his brief. Mine is about the same length. If it has been distributed to the senators, I will not go through the whole thing. I will leave it up to you. I can read it, or make some opening, off-the-cuff remarks.

The Chairman: Why do you not simply hit the highlights of your brief?

Mr. Brazier: This proposed legislation was developed through a tripartite consensus process. That actually transpired over a seven-year period, because the initial efforts to get amendments to Part II of the Canada Labour Code unfortunately ran afoul of the House of Commons being dissolved for a federal election.

If the reports in the papers are correct, there may be another federal election in the offing. I know I can speak on behalf of the CLC, Mr. Yussuff, and the HRDC, when I say that we do not want this bill to suffer the same fate as its predecessor.

We urge you to pass the proposed legislation.

There were some areas that had been agreed to in a consensus process that never found their way into the bill. We requested jointly with the unions that these amendments be made and a number of them were.

Other suggested amendments were not made. Neither we nor the unions are requesting additional amendments, because at this juncture the process will simply be delayed.

Having reviewed the union's brief — I just received a copy before the hearing started — I see that we have both identified what we believe to be a glaring problem with the bill. The government did not see fit to include in the bill the appeal process that both labour and management believe is necessary for proper due process.

We agreed upon a two-tier appeal process during the consultations, but it never appeared in the bill.

I go into some detail about this, and I notice that the CLC brief does too. I will not say anything further.

We did discuss this matter jointly. We and the CLC met with HRDC to discuss this. Unfortunately, we could not get a resolution.

They have suggested as a partial resolution — and it certainly does not resolve the basic problem — that the appeal officer mechanism in the bill be moved administratively from HRDC to the Canada Industrial Relations Board. That would get around one of the problems associated with the appeal process. The way the

plus tard. La ministre a expliqué le projet de loi hier; quant à nous, nous répondrons volontiers aux questions que les sénateurs voudront bien nous poser.

Au nom du Congrès et de nos collègues, nous vous remercions de nous permettre de vous exposer notre point de vue. Nous attendons vos questions.

M. Don Brazier, directeur exécutif, Employeurs des transports et communications de régie fédérale: Je remarque que M. Yussuff n'a pas lu son mémoire. Le mien est à peu près de la même longueur. Si on l'a distribué aux sénateurs, je ne vais pas le lire au complet. Je vous laisserai le faire vous-mêmes. Je peux peut-être faire quelques remarques générales pour commencer.

Le président: Pourquoi ne faites-vous pas simplement ressortir les points saillants de votre mémoire?

M. Brazier: Le projet de loi est le résultat d'un consensus entre trois parties. Les discussions se sont déroulées sur une période de sept ans, parce que les premières initiatives prises pour modifier la partie II du Code canadien du travail ont échoué après que la Chambre des communes a été dissoute pour la tenue d'élections générales.

Si ce qu'on lit dans les journaux est vrai, il pourrait bien y avoir d'autres élections générales bientôt. Je sais que le CTC, M. Yussuff, et DRHC seront d'accord avec moi pour dire que nous ne voulons pas que le projet de loi connaisse le même sort que son prédécesseur.

Nous vous recommandons fortement d'adopter le projet de loi.

Il y a des sujets qui ont fait l'objet d'un consensus et qui ne se retrouvent pas dans le projet de loi. Conjointement avec les syndicats, nous avons demandé que des amendements y soient apportés et certains l'ont été.

D'autres ne l'ont pas été, mais nous ne demanderons pas de nouveaux amendements pour ne pas retarder plus longtemps le processus législatif.

Après avoir pris connaissance du mémoire du syndicat — pour en avoir reçu copie avant le début de l'audience — je constate que nous avons tous les deux cerné ce qui est pour nous une lacune importante du projet de loi. En effet, le gouvernement n'a pas jugé utile d'inclure dans le projet de loi la procédure d'appel que les syndicats et les employeurs estimaient nécessaire à l'application régulière de la loi.

Nous nous étions entendus sur une procédure d'appel à deux niveaux durant les consultations, mais il n'en est pas question dans le projet de loi.

Je donne des détails là-dessus, et je vois que le CTC le fait aussi dans son mémoire. Je n'en dirai donc pas davantage.

Nous avons discuté de la question ensemble. Avec le CTC, nous avons rencontré DRHC mais, malheureusement, nous n'avons pu en arriver à un règlement.

On a proposé — mais ce début de solution ne règle pas le problème de base — que l'agent d'appel relève administrativement non pas de DRHC mais du Conseil canadien des relations industrielles. Cela permettrait de contourner une des difficultés associées à la procédure d'appel. Selon la façon dont le

bill is worded right now, the appeal procedure and the enforcement of the proposed legislation are within the same organization. We are uncomfortable with the same boss directing both the enforcement of the bill and the appeal procedure.

Certainly, moving it to another agency like the CIRB would address a certain aspect of the problem, but not all of it.

We reluctantly accepted the government's proposal, on the understanding that we will revisit the appeal procedure at a later date. Perhaps at some later point, when the Canada Labour Code is opened up for enactment, we can see whether we should be making further amendments to Part II.

That constitutes the essence of my comments, Mr. Chairman, and honourable senators.

I would conclude, as I did in my written comments, that we request that this bill be passed by your chamber as expeditiously as possible.

The Chairman: I was going to enquire about the appeals procedure just as a matter of interest.

Is it fair to say that the two of you developed an appeals procedure by consensus? This is what I get from both of your briefs.

Labour and management developed a consensus appeals procedure that the government did not accept. Is that a fair statement?

Mr. Yussuff: That would be a fair statement, yes.

The Chairman: Why was it not accepted?

Mr. Yussuff: The advice we were given when we raised it earlier, when the bill was before the House committee, was that enactment would be delayed. It would not make it through the spring session of the House and would be further delayed.

The Chairman: In other words, the consensus appeals process was rejected not on the grounds that it was unacceptable public policy, but simply because drafting the required amendments and getting them through would delay the process. Is that correct?

Mr. Yussuff: That is not exactly clear. There was a consensus between labour and the employers on the appeal process that was not initially included in the bill. We continued to raise it when the bill was put back into the parliamentary process. We thought we could have worked it out before it got to second and third reading. We could not do that. However, we did have a consensus process prior to second and third reading, but it was not included because HRDC unilaterally inserted a single process of appeal with which we did not agree.

The Chairman: Mr. Brazier, is that a fair summary of your position?

Mr. Brazier: Yes. Unfortunately, I do not have quite the background on the bill as some of the union officers, especially Mr. Bennie. This was all developed prior to my getting involved.

projet de loi est libellé actuellement, c'est la même organisation qui s'occupe de l'instruction des appels et de l'application de la loi. Nous n'aimons pas que ce soit le même responsable qui fasse appliquer la loi et entende les appels.

Confier cette responsabilité à un organisme tel que le Conseil canadien des relations industrielles réglerait certes le problème en partie, mais pas dans sa totalité.

Nous avons finalement accepté la proposition du gouvernement, étant entendu que la procédure d'appel sera réexaminée plus tard. Quand le processus législatif le permettra, nous pourrions examiner la possibilité d'apporter d'autres modifications à la partie II du Code canadien du travail.

Voilà essentiellement ce que j'avais à dire, monsieur le président et honorables sénateurs.

Je terminerai en demandant, comme je le fais dans mon mémoire, que le Sénat adopte le projet de loi le plus rapidement possible.

Le président: J'aimerais vous poser une question sur la procédure d'appel.

Peut-on dire que la procédure d'appel que vos deux organismes ont élaborée est le résultat d'un consensus? C'est ce que je comprends de vos deux mémoires.

Les syndicats et les employeurs se sont entendus sur une procédure d'appel que le gouvernement n'a pas acceptée. Est-ce qu'on peut dire cela?

M. Yussuff: On peut le dire, oui.

Le président: Pourquoi ne l'a-t-on pas acceptée?

M. Yussuff: On nous a expliqué, quand nous avons soulevé la question au moment où le comité de la Chambre examinait le projet de loi, que l'adoption du projet de loi serait retardée. Il ne pourrait franchir toutes les étapes à la Chambre ce printemps et son adoption serait retardée.

Le président: Autrement dit, la procédure convenue a été rejetée non pas parce qu'elle était inacceptable, mais simplement parce que la préparation des amendements retarderait le processus d'adoption du projet de loi. Est-ce exact?

M. Yussuff: Ce n'est pas tout à fait clair. Les travailleurs et les employeurs se sont entendus au sujet d'une procédure d'appel qui n'a pas été incluse au départ dans le projet de loi. Nous avons soulevé la question quand le projet de loi a été présenté au Parlement. Nous pensions pouvoir trouver une solution avant les étapes de la deuxième et de la troisième lecture, mais cela n'a pas été possible. Nous en étions cependant arrivés à un consensus au préalable, mais la formule n'a pas été retenue parce que DRHC a décidé unilatéralement de prévoir une procédure d'appel unique avec laquelle nous n'étions pas d'accord.

Le président: Monsieur Brazier, cela résume-t-il bien votre point de vue?

M. Brazier: Oui. Malheureusement, je ne connais pas aussi bien l'historique du projet de loi que certains représentants syndicaux, comme M. Bennie, parce que cela s'est passé avant que j'intervienne dans le dossier.

That is as I understand it. I did attend a tripartite meeting, as I mentioned, with the unions and HRDC. Certainly they seemed to be concerned about the dual or two-stage appeal procedure.

They seemed to have some concern about what they believe are two quasi-judicial appeal procedures. We do not have the same problem because we believe that the two-stage appeal procedure is necessary if we are to have fairness and due process in the administration of health and safety.

The other issue was timeliness, as Mr. Yussuff mentioned. If we have to go back to the Department of Justice and draft these consequential amendments to the Public Service Staff Relations Act and to the Canada Labour Code, et cetera, we will not be able to get the bill through Parliament before the summer recess.

There was a problem both with the two-stage process and with the delay, so there were substantive as well as procedural concerns.

Senator Robertson: Coming back to your tripartite committee, did you make other recommendations regarding this bill that were not accepted, besides the appeals process? Did you have any other ideas on the table that were left aside or not accepted?

Mr. Brazier: I would turn that question over to CLC, because they raised some consensus issues before the House of Commons committee with which we did not agree.

I cannot give you details because I do not have the same intimate background as some of the others. We supported them because they were part of the consensus process. Not everything that the CLC raised before the House of Commons committee, and to which we agreed, ended up in the bill. Some did; some did not.

Mr. Yussuff: The appeal process certainly was a tripartite proposal with which we agreed. Other suggested amendments and issues that we have raised and highlighted here are not a representation of the tripartite process, even though we have some agreement that they should be included in the proposed legislation.

Senator Robertson: When the minister was here yesterday, we talked about violence in the workplace. That seems to be omitted in the bill. We had some assurance from the minister that they are looking at methods of dealing with violence in the workplace through amendments.

It seemed to me that that should be in the next round of study. Hopefully it does not take so many years to open it up again. It is a slow process, as we know. There should almost be a standing tripartite committee to keep mopping up things that arise in something as important as a labour code.

Will there be a continuation of this committee, or is your work over now?

C'est ce que j'en comprends. Comme je l'ai dit, j'ai assisté à une réunion des trois parties, avec les syndicats et DRHC. On semblait certes préoccupé par la procédure d'appel à deux niveaux.

Ce sont les deux procédures d'appel quasi judiciaires qui semblait inquiéter le ministère. Ce n'était pas un problème pour nous parce que nous croyons qu'une procédure d'appel à deux niveaux est nécessaire pour assurer l'équité et l'application régulière de la loi en matière de santé et de sécurité.

La question des délais était un autre problème, comme M. Yussuff l'a dit. S'il faut demander au ministère de la Justice de rédiger les amendements consécutifs qu'il faut apporter à d'autres textes de loi, comme la Loi sur les relations de travail dans la fonction publique et le Code canadien du travail, nous ne pourrions pas faire adopter le projet de loi avant le congé d'été.

La procédure à deux niveaux et les délais causaient des problèmes, et je dirais que les préoccupations portaient autant sur des questions de fond que des formalités.

Le sénateur Robertson: Pour revenir à vos discussions tripartites, avez-vous formulé d'autres recommandations qui ne figurent pas dans le projet de loi, à part la procédure d'appel? Y a-t-il d'autres propositions qui ont été écartées ou rejetées?

M. Brazier: Je vais laisser le CTC répondre parce qu'il a soulevé des questions à ce sujet devant le comité de la Chambre des communes avec lesquelles nous n'étions pas d'accord.

Je ne peux pas vous donner de détails parce que je ne connais pas le dossier aussi bien que d'autres. Nous avons approuvé des points parce qu'ils faisaient partie des mesures ayant fait l'objet d'un consensus. Ce ne sont pas toutes les questions dont le CTC a parlé devant le comité de la Chambre des communes, et que nous avons approuvées, qui se sont retrouvées dans le projet de loi. Certaines y figurent, d'autres pas.

M. Yussuff: La procédure d'appel a été approuvée par les trois parties. D'autres modifications proposées et mises en évidence ici n'ont pas été approuvées par les trois parties, même s'il a été jusqu'à un certain convenu qu'elles devraient figurer dans le projet de loi.

Le sénateur Robertson: Quand la ministre est venue nous rencontrer hier, nous avons parlé de la violence au travail. Il ne semble pas en être question dans le projet de loi. La ministre nous a en quelque sorte assurés qu'on cherche des moyens de s'occuper de la violence au travail et que des modifications seront apportées à ce sujet.

Il me semble que cela devrait faire partie de la prochaine ronde de discussions. Il reste à espérer qu'on n'attendra pas aussi longtemps avant de l'entreprendre. C'est un long processus, comme nous le savons. On devrait presque établir un comité tripartite permanent pour régler les questions qui se présentent sur un sujet aussi important que le Code du travail.

Le comité va-t-il poursuivre ses travaux, ou a-t-il mis un terme à ses activités?

Mr. Yussuff: I wish it were that simple. The work is never over, of course. I will let my colleagues comment specifically, but to respond to your inquiry about workplace violence, there is ongoing work on regulations to deal with that, both external and internal. My colleague, Mr. Bennie, will respond specifically.

We are very close to finalizing those regulations because we feel they are of the utmost importance.

We have just had a tripartite meeting with HRDC, labour, and the CLC to discuss the OC Transpo recommendations, the whole question of workplace violence, how to get the regulations moving, and where we have consensus.

Senator Robertson: Do you see tackling the violence issue in the regulations as a trial period, and if they seem to be satisfactory, that they will perhaps be placed in a firmer position through legislative amendments?

Mr. Jeff Bennie, National Union Representative, Canadian Union of Postal Workers: We have established — again through a consensus agreement — that there will now be an employer duty under the legislation in section 125 to take prescribed steps to prevent, and protect against, violence in the workplace.

Two working groups have been established. One deals with violence in the workplace from external sources; that is, people who are coming in from outside the workplace. We are also developing prevention program regulation to deal with internal sources of violence; that is, other employees or supervisors, et cetera.

We think that those two regulations, when adopted, should put good tools into the hands of workplace parties to deal with this issue.

I smiled when you suggested an ongoing standing committee to look at such issues, because that was one of the recommendations on which both labour and management agreed, but it was rejected by the government.

Senator Robertson: What a shame. You win some and you lose some.

Mr. Bennie: That is right.

[Translation]

Senator Pépin: As far as pregnant or nursing workers are concerned, on page 3 of your brief, it says that there is a difference between what the Quebec workers get and what the Public Service Alliance of Canada is offering. Could you elaborate on that?

Mr. Denis St-Jean, Health and Safety Officer, Public Service Alliance of Canada: Indeed, the precautionary cessation of work included in the bill has nothing to do with the provincial system of protective reassignment. The difference lies in the period between the start of the pregnancy and the issuance of a medical certificate. During that time, there is a precautionary cessation of work with full compensation. As soon as the medical certificate has been

M. Yussuff: J'aimerais que ce soit aussi simple. Le travail n'est jamais fini, bien sûr. Je vais laisser mes collègues vous en parler davantage, mais pour répondre à votre question sur la violence au travail, on travaille actuellement à la rédaction d'un règlement sur la violence exercée au travail autant par des gens de l'extérieur que de l'intérieur. Mon collègue, M. Bennie, pourra vous en dire plus long à ce sujet.

Nous sommes sur le point de mettre la dernière main au règlement parce nous estimons qu'il est de la plus haute importance.

Nous venons de nous réunir, DRHC, les travailleurs et le CTC pour discuter des recommandations d'OC Transpo, de toute la question de la violence au travail, de la façon de donner suite au règlement et des éléments qui font l'objet d'un consensus.

Le sénateur Robertson: Est-ce que les mesures pour lutter contre la violence sont mises à l'essai dans le règlement et, si elles s'avèrent satisfaisantes, elles pourraient être confirmées en étant inscrites dans la loi?

M. Jeff Bennie, représentant syndical national, Syndicat des travailleurs et travailleuses des postes du Canada: Nous avons convenu — par consensus — que ce serait désormais une des obligations de l'employeur, aux termes de l'article 125 de la loi, de prendre les mesures prévues par les règlements pour prévenir et réprimer la violence dans le lieu de travail.

Deux groupes de travail ont été formés. L'un d'eux s'occupe de la violence au travail provenant de sources externes, c'est-à-dire de personnes extérieures au milieu de travail. Nous sommes également en train de préparer un règlement relatif à un programme de prévention des sources de violence interne, c'est-à-dire la violence exercée par d'autres employés, les superviseurs, et cetera.

Nous pensons que ces deux règlements, une fois adoptés, seront des outils utiles pour régler les problèmes de cette nature en milieu de travail.

J'ai souri quand je vous ai entendu proposer qu'on forme un comité permanent pour examiner ces questions, parce que c'est une recommandation que les travailleurs et les employeurs ont formulée, mais elle a été rejetée par le gouvernement.

Le sénateur Robertson: C'est dommage. On ne peut pas gagner pas à tout coup.

M. Bennie: C'est vrai.

[Français]

Le sénateur Pépin: En ce qui concerne les travailleuses enceintes ou qui allaitent, à la page 3 de votre mémoire, on dit qu'il y a une différence entre ce que les travailleuses du Québec reçoivent et ce que l'Alliance de la fonction publique du Canada offre. Pourriez-vous élaborer un peu plus?

M. Denis St-Jean, agent en santé et sécurité, Alliance de la fonction publique du Canada: Effectivement, le retrait préventif qui se trouve à l'intérieur du projet de loi n'est en rien comme le système offert sous le régime provincial pour le retrait de la femme enceinte. La distinction est de couvrir la période entre le moment où la travailleuse est enceinte et où elle doit aller chercher un certificat médical. Pour cette période de temps, il y a

delivered, the worker is no longer protected by Part II of the Code. She is then covered by Part III which, to be very clear, allows for a precautionary cessation of work only, without financial compensation, thus without pay. This is the first aspect which is giving us problems.

Moreover, Part III of the Code does not apply to federal public servants. We had to negotiate with the employer a policy offering a coverage similar to what you will find in Part III of the Code, that is a precautionary cessation of work without financial compensation. We feel this is unfair and our position is to get a precautionary cessation of work system that applies coast-to-coast to all Canadian women workers.

Senator Pépin: If I understand you correctly, the worker who cannot work during the last three months of her pregnancy has no revenue?

Mr. St-Jean: Unless her workstation can be adapted and she can be assigned to other duties for which she has the necessary skills. But, yes, she will have no financial compensation for the precautionary cessation of work.

Senator Pépin: I am reading the brochure entitled "It's time to enact health and safety legislation for Parliament Hill workers." If I understand this correctly, there is also a difference there. It says that employees who work on Parliament Hill do not have exactly the same coverage.

Mr. St-Jean: Indeed, Parliament Hill workers are not covered by a health and safety act such as Part II of the Canada Labour Code. When the Alliance attempted to unionize Parliament Hill employees, some 13 years ago, a specific act was passed, the Parliamentary Employment and Staff Relations Act, to give them rights as workers. This Act was divided into three chapters, the first covering staff relations and the whole certification process. The third chapter refers to Parliament Hill workers' rights in the area of health and safety. Unfortunately, that part of the Act was never proclaimed. We are therefore in a position where parliamentary workers are amongst the only ones in all of Canada who are not legally protected by health and safety standards. This is a bit contradictory since, during our research leading to the document you mentioned earlier, we realized that all provincial legislatures were offering a health and safety protection identical to what the province's workers were getting.

In addition, the U.S. Congress employees faced this same situation some years ago. You will in fact find quotations in the brochure we distributed today by which we recognized that this situation was totally unfair. We passed a specific law ensuring the existence of health and safety rights for employees. Even more ironical, the British Parliament also has a specific law applying to

un retrait préventif avec pleine compensation. Au moment où le certificat médical est émis, la travailleuse n'a plus le droit à la protection de la partie II du code et est par la suite couverte par la partie III du code qui, pour être très clair, offre seulement un retrait préventif sans compensation financière, donc sans solde. C'est le premier élément avec lequel on a des problèmes.

De plus, la partie III du code ne s'applique pas aux employés de la fonction publique fédérale. Nous avons dû négocier avec l'employeur une politique qui offre une couverture similaire, qui se trouve à la partie III du code, donc un retrait préventif sans compensation financière. Nous considérons cette situation injuste et notre position est d'obtenir un régime de retrait préventif applicable à toutes les travailleuses d'un océan à l'autre du Canada.

Le sénateur Pépin: Si j'ai bien compris, la travailleuse qui ne peut pas travailler pendant les derniers trois mois de sa grossesse n'a aucun revenu?

M. St-Jean: À moins que l'on puisse adapter son poste de travail et l'affecter à d'autres postes pour lesquels elle a les compétences nécessaires. Effectivement, elle se retrouverait dans une situation où elle n'aurait aucune compensation financière pour son retrait préventif, si on peut l'appeler ainsi.

Le sénateur Pépin: Je lis le document intitulé: «C'est le temps de promulguer la Loi sur la santé et la sécurité des travailleurs et des travailleuses au Parlement». Si je comprends bien, là aussi il y a une différence. On y dit que les employés qui travaillent sur la Colline parlementaire n'ont pas, eux non plus, tout à fait la même protection.

M. St-Jean: Effectivement, les travailleuses et les travailleurs de la Colline parlementaire ne profitent pas de la couverture d'une loi en santé et sécurité dont la partie II du Code canadien du travail. Au moment où l'Alliance a tenté de syndiquer les employés du Parlement, il y a environ 13 ans, nous avons adopté une loi spécifique, la Loi sur les relations de travail du Parlement, pour leur reconnaître des droits en tant que travailleurs. Cette loi a été divisée en trois chapitres dont le premier étant les relations de travail et tout le processus d'accréditation. Le troisième chapitre étant celui qui réfère aux droits en matière de santé et sécurité pour les employés du Parlement. Malheureusement, nous n'avons jamais assermenté cette partie de la loi. Alors, nous nous retrouvons devant une situation où les employés du Parlement sont parmi les seuls à travers le Canada à n'avoir aucune protection légale de santé et sécurité. Ce qui est un peu contradictoire puisque lors de nos recherches pour écrire le document dont vous parliez tout à l'heure, nous nous sommes aperçus que toutes les assemblées législatives provinciales offraient une protection de santé et sécurité identique à celles des travailleurs de leur province.

En plus, les employés du Congrès américain ont fait face à la même situation il y a quelques années. D'ailleurs, on a des citations à l'intérieur du manuel que nous avons distribué aujourd'hui et par lequel on a reconnu que c'était une situation tout à fait injuste. Nous avons passé une loi particulière pour s'assurer qu'il y ait des droits en santé et sécurité. Encore plus

British Parliament employees who are therefore covered by health and safety standards in the workplace.

In conclusion, for some unknown reason — even if we knocked on all doors to get answers — the Canadian Parliament employees are totally excluded and have no fundamental rights in the area of health and safety, which goes against all international conventions on health and safety.

Senator Gill: What do they get in return? What are you proposing? What should they have? What is replacing this protection?

Mr. St-Jean: They are not covered by any law. The only answer they have got is that the employer will voluntarily follow regulations and legislation. Unfortunately, this seems unacceptable to us. There should be a minimum of legislation in respect of these employees.

In answer to your question, no, there is no health and safety act in relation to Parliament Hill employees. They therefore have no legal right to be informed of and take part in the consultation process related to health and safety, much less the right to refuse dangerous work.

Senator Gill: What is your impression? Why is it such?

Mr. St-Jean: When we asked the people implicated in this issue, we observed that they are greatly concerned by the right to refuse dangerous work for Parliament employees. They fear that such a right will lead to the closing down of parliamentary operations. This is a myth since in the last years, there has been almost no history of a federally regulated business closing because of the right to refuse. The bill allows for a consultation process to try and resolve conflicts. There's a chapter in the bill which even allows for the workers' participation in order to resolve health and safety problems. The only answer we were able to get in those 13 years, in spite of what was sent to the Prime Minister, to the House Speaker and others, is very simply that they will continue to consider the proclamation of Part III of the Parliamentary Employment and Staff Relations Act.

[English]

Senator Cohen: Bill C-12 speaks to the Coal Mining Safety Commission because of the specific dangers that exist in that particular industry.

In the opinion of the Canadian Labour Congress, are there any other occupations or fields that you feel might benefit from being named in Bill C-12? I am looking at proposed subsection 137.1.

Mr. Bennie: The interesting thing about clause 137 is that it applies to the Cape Breton Development Corporation, which as we know, has ceased to exist as an entity. The Coal Mining Safety Commission was established for one particular mine that no longer exists.

ironique, le Parlement britannique a lui aussi une loi spécifique qui s'applique aux employés du Parlement britannique donc, qui ont une couverture en santé et sécurité.

En conclusion, les employés du Parlement canadien, pour une raison qu'on ignore — même si on a cogné à toutes les portes pour trouver les réponses à nos questions — sont totalement exclus et n'ont aucun droit de base en santé et sécurité ce qui va à l'encontre de toutes les conventions internationales en santé et sécurité.

Le sénateur Gill: Qu'ont-ils en retour? Que suggérez-vous? Que devrait-il exister? Qu'est-ce qui remplace cela?

M. St-Jean: Aucune loi ne s'applique à eux. Tout ce qu'on a pour eux, c'est une réponse qu'ils vont, de façon volontaire, suivre la réglementation et les lois. Malheureusement pour nous cela semble être une condition inacceptable. On devrait avoir un minimum de lois applicables à ces employés.

Pour répondre à votre question, non, il n'y a aucune loi de santé et de sécurité qui s'applique aux employés du Parlement. Ils n'ont donc pas le droit légal de connaître et de participer au processus de consultation en matière de santé et de sécurité et encore moins le droit de refus pour un travail dangereux.

Le sénateur Gill: Quelle est votre impression? Pourquoi est-ce comme cela?

M. St-Jean: Lorsque nous posons la question aux personnes impliquées dans le dossier, nous constatons une grande préoccupation avec le droit de refus du travail pour les travailleurs du Parlement. Ils ont peur qu'un droit de refus entraîne la fermeture des opérations parlementaires. Pour nous, c'est un mythe puisque l'historique en santé et sécurité des dernières années comme la fermeture d'une entreprise de compétence fédérale, suite à un droit de refus, est à peu près inexistante. Le projet de loi prévoit un processus de consultation pour essayer de résoudre les conflits. Il y a un chapitre à l'intérieur du projet de loi qui ajoute même une participation des travailleurs pour trouver des solutions aux problèmes de santé et de sécurité. La seule réponse que nous avons pu trouver depuis ces 13 années, malgré les lettres envoyées au premier ministre, au président de la Chambre et autres, c'est tout simplement qu'ils vont continuer à considérer de promulguer la partie III de la Loi des relations de travail du Parlement.

[Traduction]

Le sénateur Cohen: Il est question de la Commission de la sécurité dans les mines de charbon dans le projet de loi C-12 en raison des dangers particuliers qui existent dans cette industrie.

Le Congrès du travail du Canada estime-t-il qu'il y a d'autres métiers ou domaines qui auraient avantage à être cités dans le projet de loi C-12? J'en suis à l'article 137.1 du projet de loi.

M. Bennie: Ce qui est intéressant au sujet de l'article 137, c'est qu'il s'applique à la Société de développement du Cap-Breton qui, comme nous le savons, n'existe plus. La Commission de la sécurité dans les mines de charbon a été créée pour une mine en particulier qui n'est plus exploitée.

Generally, Part II applies to all workers in the federal jurisdiction, whether you are talking about workers on trains, flight attendants, postal workers, or workers for the federal government, et cetera. They are all covered by Part II.

We are currently in the midst of trying to develop some specific regulatory standards on violence affecting workers in the armoured-car industry, because of some particular staffing problems and in getting protective equipment for armoured-car workers. We tried to examine and develop those specific issues more within regulations than in the act itself.

Mr. Yussuff: I want to thank the senators for their inquiries into the specific areas that we have highlighted. To close, this is likely our last opportunity, in this long, seemingly endless process, of getting this bill into the law of this country.

I thank the minister for moving this bill forward, but I would also thank you in advance for hopefully getting this bill adopted as soon as possible. When Mr. Bennie started out on this, he was a young man with no grey hair. He has aged after seven years of exhaustive work and somebody is responsible for this. One way to reward him is by passing this bill and making it the law of this country.

The Chairman: I do not detect any suggestions around the table for amendments. If I am correct, then I would be happy to accept a motion that we dispense with clause-by-clause consideration of Bill C-12.

Senator LeBreton: I so move.

The Chairman: Can I have a motion that Bill C-12 be reported to the Senate without amendment?

Senator LeBreton: I so move.

The Chairman: I will then do that tomorrow.

Thank you for coming, gentlemen.

Honourable senators, we have another item before us, Bill S-5, an act to amend the Parliament of Canada Act to deal with the Parliamentary Poet Laureate. I again understand from informal consultations that nobody is looking to introduce an amendment. Could I have a motion to dispense with clause-by-clause consideration?

Senator Carstairs: I so move.

The Chairman: Could I have a motion to report Bill S-5 without amendment?

Senator Fairbairn: I so move.

Senator Grafstein: Thank you.

The Chairman: Thank you, honourable senators, for coming. You will be receiving a draft report on phase 1 of the medical study during the summer.

The committee adjourned.

En général, la partie II s'applique à tous les travailleurs du secteur public fédéral, qu'ils soient employés des chemins de fer, agents de bord, travailleurs des postes ou autres. Ils sont tous visés par la partie II.

Nous essayons actuellement d'établir des normes précises sur la violence qui touche ceux qui travaillent dans des entreprises de transport par camions blindés, parce que ces entreprises connaissent certains problèmes de dotation et pour assurer de l'équipement protecteur aux travailleurs. Nous essayons d'établir des normes qui figureront dans un règlement et non dans la loi.

M. Yussuff: Je veux remercier les sénateurs de leurs questions sur les domaines précis que nous avons fait ressortir. Pour terminer, c'est probablement la dernière occasion qui nous est offerte, dans ce long processus qui semble interminable, de faire adopter le projet de loi.

Je remercie la ministre d'avoir proposé le projet de loi, mais j'aimerais aussi vous remercier à l'avance de faire en sorte qu'il soit adopté le plus tôt possible. Quand M. Bennie a commencé à s'occuper de ce dossier, c'était un jeune homme sans cheveux gris. Sept années de travail intensif l'on fait vieillir, et ce serait une façon de le récompenser que d'adopter le projet de loi et de s'assurer qu'il a force de loi dans notre pays.

Le président: Je ne pense pas qu'on ait des amendements à suggérer. Si c'est le cas, j'aimerais qu'on présente une motion pour nous dispenser d'étudier le projet de loi C-12 article par article.

Le sénateur LeBreton: J'en fais la proposition.

Le président: Peut-on présenter une motion demandant qu'il soit fait rapport du projet de loi C-12 au Sénat sans amendement?

Le sénateur LeBreton: J'en fais la proposition.

Le président: Je vais donc en faire rapport au Sénat demain.

Merci beaucoup messieurs d'être venus nous rencontrer.

Honorables sénateurs, nous avons un autre projet de loi à étudier, le projet de loi S-5, Loi modifiant la Loi sur le Parlement du Canada, concernant le poète officiel du Parlement. Je crois comprendre, d'après les conversations que j'ai eues, que personne n'a d'amendement à proposer. Peut-on présenter une motion pour nous dispenser d'étudier le projet de loi article par article?

Le sénateur Carstairs: J'en fais la proposition.

Le président: Peut-on proposer une motion pour qu'il soit fait rapport du projet de loi S-5 sans amendement?

Le sénateur Fairbairn: J'en fais la proposition.

Le sénateur Grafstein: Merci.

Le président: Merci, honorables sénateurs, de votre présence. Vous recevrez cet été l'ébauche du rapport sur la phase 1 de l'étude sur la santé.

La séance est levée.



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APPEARING—COMPARAÎT

The Honourable Claudette Bradshaw, P.C., M.P., Minister of
Labour.

L'honorable Claudette Bradshaw, c.p., députée, ministre du
Travail.

WITNESSES—TÉMOINS

Tuesday, June 20, 2000

Human Resources Development Canada:

Narren Edmonson, Assistant Deputy Minister, Labour;
Gerry Blanchard, Director General, Labour Operations;
Bill Worona, Director, Occupational Safety and Health and
Fire Prevention;
Rick Seamen, Program Advisor, Occupational Safety and
Health Compliance Unit;

Wednesday, June 21, 2000

Canadian Labour Congress:

Hassan Yussuff, Executive Vice-President.

Canadian Union of Postal Workers:

Jeff Bennie, National Union Representative.

Public Service Alliance of Canada:

Denis St-Jean, Health and Safety Officer.

*Federally Regulated Employers — Transportation and Com-
munications (FETCO):*

Don Brazier, Executive Director

Le mardi 20 juin 2000

*Développement des ressources humaines Canada —
Programme du travail:*

Warren Edmonson, sous-ministre adjoint, Travail;
Gerry Blanchard, directeur général, Opération du travail;
Bill Worona, directeur, Sécurité et santé au travail et
prévention des incendies;
Rick Seaman, conseiller de programme, Unité d'observation
de l'hygiène et de la sécurité du travail.

Le mercredi 21 juin 2000

Du Congrès du travail du Canada:

Hassan Yussuff, vice-président directeur.

*Du Syndicat des travailleurs et travailleuses des postes du
Canada:*

Jeff Bennie, représentant syndical national.

De l'Alliance de la fonction publique du Canada:

Denis St-Jean, agent en santé et sécurité.

*D'Employeurs des transports et communications de régie
fédérale (ETCOF):*

Don Brazier, directeur exécutif.



Second Session
Thirty-sixth Parliament, 1999-2000

SENATE OF CANADA

*Proceedings of the Standing
Senate Committee on*

Social Affairs, Science and Technology

Chairman:
The Honourable MICHAEL KIRBY

Wednesday, September 20, 2000

Issue No. 19

First and last meeting on:
Bill C-5, An act to establish
the Canadian Tourism Commission

INCLUDING:
THE TENTH REPORT OF THE COMMITTEE
(Bill C-5)

WITNESSES:
(See back cover)

Deuxième session de la
trente-sixième législature, 1999-2000

SÉNAT DU CANADA

*Délibérations du comité
sénatorial permanent des*

Affaires sociales, des sciences et de la technologie

Président:
L'honorable MICHAEL KIRBY

Le mercredi 20 septembre 2000

Fascicule n° 19

Première et dernière réunion concernant:
Le projet de loi C-5, Loi constituant
la Commission canadienne du tourisme

Y COMPRIS:
LE DIXIÈME RAPPORT DU COMITÉ
(le projet de loi C-5)

TÉMOINS:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Cook
Beaudoin	Fairbairn, P.C.
* Boudreau, P.C. (or Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Robertson

* *Ex Officio Members*

(Quorum 4)

Change in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Kennedy substituted for that of the Honourable Senator Pépin (*September 15, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjory LeBreton

et

Les honorables sénateurs:

Banks	Cook
Beaudoin	Fairbairn, c.p.
* Boudreau, c.p. (ou Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Robertson

* *Membres d'office*

(Quorum 4)

Modification de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Kennedy substitué à celui de l'honorable sénateur Pépin (*le 15 septembre 2000*).

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Wednesday, June 28, 2000:

Resuming debate on the motion of the Honourable Senator Callbeck, seconded by the Honourable Senator Cook, for the second reading of Bill C-5, An Act to establish the Canadian Tourism Commission.

After debate,

The question being put on the motion, it was adopted.

The Bill was then read the second time.

The Honourable Senator Callbeck moved, seconded by the Honourable Senator Cook, that the Bill be referred to the Standing Senate Committee on Social Affairs, Science and Technology.

The question being put on the motion, it was adopted.

ORDRE DE RENVOI

Extrait des *Journaux du Sénat* du mercredi 28 juin 2000:

Reprise du débat sur la motion de l'honorable sénateur Callbeck, appuyée par l'honorable sénateur Cook, tendant à la deuxième lecture du projet de loi C-5, Loi constituant la Commission canadienne du tourisme.

Après débat,

La motion, mise aux voix, est adoptée.

Le projet de loi est alors lu la deuxième fois.

L'honorable sénateur Callbeck propose, appuyé par l'honorable sénateur Cook, que le projet de loi soit renvoyé au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

La motion, mise aux voix, est adoptée.

Le greffier du Sénat,

Paul Bélisle

Clerk of the Senate

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, September 20, 2000

(27)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 3:50 p.m., the Chairman, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Banks, Callbeck, Carstairs, Cohen, Fairbairn, P.C., Kennedy, Kirby, Keon and LeBreton (9).

Other senator present: The Honourable Senator Jane Marie Cordy (1).

In attendance: From the Research Branch of the Library of Parliament: Gérard Lafrenière

Also in attendance: The official reporters of the Senate.

WITNESSES:

From the Canadian Tourism Commission:

Jim Watson, President;

Roger Wheelock, Vice-President, Marketing;

Chantal Péan, Director, Industry and Corporate Affairs.

From Industry Canada:

Irving Miller, Senior Counsel, Legal Services.

Pursuant to the Order of Reference adopted by the Senate on Wednesday, June 28, 2000, the committee began its consideration of the Bill C-5, An Act to establish the Canadian Tourism Commission.

The Chairman made a statement.

Mr. Watson made a statement and, together with Mr. Wheelock, answered questions.

It was moved by Senator Banks — That the committee proceed to clause-by-clause consideration of Bill C-5.

The question being put on the motion, it was adopted.

It was moved by Senator Carstairs — That the committee dispense with clause-by-clause consideration of Bill C-5.

The question being put on the motion, it was adopted.

It was moved by Senator LeBreton — That the Chairman report Bill C-5 to the Senate without amendment.

The question being put on the motion, it was adopted.

At 4:57 p.m., the committee adjourned to the call of the Chair.

ATTEST:

PROCÈS-VERBAL

OTTAWA, le mercredi 20 septembre 2000

(27)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 15 h 50, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Banks, Callbeck, Carstairs, Cohen, Fairbairn, c.p., Kennedy, Kirby, Keon et LeBreton (9).

Autre sénateur présent: L'honorable sénateur Jane Marie Cordy (1).

Également présent: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Gérard Lafrenière.

Aussi présents: Les sténographes officiels du Sénat.

TÉMOINS:

De la Commission canadienne du tourisme:

Jim Watson, président;

Roger Wheelock, vice-président, Marketing;

Chantal Péan, directrice, Affaires internes et de l'industrie.

D'Industrie Canada:

Irving Miller, avocat-conseil, Services juridiques.

Conformément à l'ordre de renvoi adopté par le Sénat le mercredi 28 juin 2000, le comité entreprend son étude du projet de loi C-5, Loi constituant la Commission canadienne du tourisme.

Le président fait une déclaration.

M. Watson fait une déclaration et, avec l'aide de M. Wheelock, répond aux questions.

Il est proposé par l'honorable sénateur Banks — Que le comité procède à l'étude article par article du projet de loi C-5.

La question, mise aux voix, est adoptée.

Il est proposé par le sénateur Carstairs — Que le comité se passe de l'étude article par article du projet de loi C-5.

La question, mise aux voix, est adoptée.

Il est proposé par le sénateur LeBreton — Que le président fasse rapport du projet de loi C-5 au Sénat sans amendement.

La question, mise aux voix, est adoptée.

À 16 h 57, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

REPORT OF THE COMMITTEE

Thursday, September 21, 2000

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to present its

TENTH REPORT

Your Committee, to which was referred Bill C-5, An Act to establish the Canadian Tourism Commission, in obedience to the Order of Reference of Wednesday, June 28, 2000, has examined the said bill and now reports the same without amendment.

Respectfully submitted,

Le président,

MICHAEL KIRBY

Chairman

RAPPORT DU COMITÉ

Le jeudi 21 septembre 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de présenter son

DIXIÈME RAPPORT

Votre comité, auquel a été déféré le Projet de loi C-5, Loi constituant la Commission canadienne du tourisme, conformément à l'ordre de renvoi du mercredi 21 juin 2000, a étudié ledit projet de loi et en fait maintenant rapport sans modifications.

Respectueusement soumis,

EVIDENCE

OTTAWA, Wednesday, September 20, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill C-5, to establish the Canadian Tourism Commission, met this day at 3:50 p.m. to give consideration to the bill.

Senator Michael Kirby (*Chairman*) in the Chair.

[English]

The Chairman: Honourable senators, we are here to discuss the issues surrounding Bill C-5, an act to establish the Canadian Tourism Commission.

Our first witness is Mr. Jim Watson.

Mr. Jim Watson, President, Canadian Tourism Commission: I cannot attest to the fact that this is a brief opening statement, but I know that if I go on too long, you will make it a brief one.

[Translation]

I am very pleased to be invited to appear before you today. I am here to present an overview of the Canadian Tourism Commission's transition from a special operating agency to a Crown corporation.

[English]

Joining me at the table are Roger Wheelock, vice-president of marketing for the Canadian Tourism Commission, who is delighted to be in the Victoria Building because he hails from Victoria; Irving Miller, senior counsel from Industry Canada; Chantal Péan, director of corporate and industry affairs for the commission.

Today I would like to discuss very briefly three main points: the reasons why the commission was created in 1995, what the commission has done for Canadian tourism over the past five years, and...

[Translation]

...and why the time is right for Bill C-5, establishing the Commission as a Crown corporation.

[English]

The context for setting up the commission is the first topic. Last week you may have noticed the front-page article in the *Ottawa Citizen* which was also published in newspapers in Halifax, Calgary, Victoria, and Winnipeg that indicated that Canada had just been voted the world's best country to visit by British readers of *Condé Nast Traveller*.

In recent years, we have become used to high praise from an increasing number of visitors, but the landscape was not always so sunny. As recently as the early 1990s for example, the Canadian tourism industry was in serious difficulty for a number of reasons. The North American recession, with climbing unemployment and interest rates, led to a sharp deterioration in the U.S. travel market. Limited air access to Canada affected emerging Asian markets, as well as established markets in the Americas and Europe. The

TÉMOIGNAGES

OTTAWA, le mercredi 20 septembre 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie auquel est renvoyé le projet de loi C-5, Loi constituant la Commission canadienne du tourisme, se réunit aujourd'hui, à 15 h 50, pour examiner ledit projet de loi.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[Traduction]

Le président: Honorables sénateurs, nous devons discuter des questions relatives au projet de loi C-5, Loi constituant la Commission canadienne du tourisme.

M. Jim Watson est notre premier témoin.

M. Jim Watson, président, Commission canadienne du tourisme: Je ne peux pas dire que ma déclaration liminaire sera brève, mais je sais que si je parle trop longtemps, vous me le ferez savoir.

[Français]

Je suis ravi d'avoir été invité à prendre la parole devant vous aujourd'hui. Je suis ici pour vous donner un aperçu de l'évolution de la Commission canadienne du tourisme, du statut d'organisme de service spécial à celui de société d'État.

[Traduction]

Je suis accompagné aujourd'hui par Roger Wheelock, vice-président du marketing de la Commission canadienne du tourisme; il est ravi de se trouver dans l'édifice Victoria, car il vient de Victoria; Irving Miller, conseiller principal à Industrie Canada; Chantal Péan, directrice des affaires internes et de l'industrie de la Commission.

Je vais aborder aujourd'hui très brièvement trois grands points: Les raisons pour lesquelles la Commission a été créée en 1995, la contribution de la Commission au secteur canadien du tourisme au cours des cinq dernières années,...

[Français]

...et enfin, la raison pour laquelle il est opportun d'adopter le projet de loi C-5, faisant de la Commission canadienne du tourisme une société d'État.

[Traduction]

Le contexte de la création de la Commission est le premier point. La semaine dernière, vous l'avez peut-être remarqué, le *Ottawa Citizen* publiait en première page un article, également publié dans les journaux de Halifax, Calgary, Victoria et Winnipeg, mentionnant que le Canada venait d'être désigné comme la meilleure destination touristique dans le monde par les lecteurs britanniques du magazine *Condé Nast Traveller*.

Nous avons pris l'habitude, ces dernières années, de recevoir les éloges d'un nombre croissant de visiteurs. Mais les choses n'ont pas toujours été aussi roses. Ainsi, il n'y a pas si longtemps, au début des années 90, l'industrie du tourisme canadien était en mauvaise posture, et ce pour plusieurs raisons. L'Amérique du Nord traversait une récession qui avait entraîné, avec la hausse du chômage et des taux d'intérêt, une détérioration brutale du marché du tourisme en provenance des États-Unis. L'accès limité de notre

building spree of the 1980s resulted in too many facilities for the decreased demand, with consequential low returns on investment.

Governments at all levels were cutting back support for the industry — federally from \$35 million annually in the 1980s to \$15 million in 1992-93.

[Translation]

All of these contributed to large operating losses in the airline and accommodation sectors.

[English]

As Senator Callbeck reminded senators when she spoke to the bill in June this year, Canadian efforts to market Canada as a tourism destination before the commission was founded were fragmented among many players — the federal government, provincial and territorial governments, and the tourism industry itself. Since it had no say in policies, the tourism industry was reluctant to form partnerships with the federal government. The result was a lack of coordinated marketing and product-development programs, further undermining industry growth. By 1992, the tourism deficit had grown to nearly \$6.5 billion annually. This represented nearly one-quarter of Canada's current account deficit and definitely caught the attention of both the previous government and the current one.

[Translation]

The Prime Minister then decided to appoint the Honourable Judd Buchanan as his special advisor on tourism. Mr. Buchanan was to recommend action to increase tourism revenues, generate tourism industry employment, and reduce the travel-account deficit.

[English]

His industry-wide consultations led Mr. Buchanan to conclude that what had been lacking was a structure through which all elements of the industry could provide meaningful input into the development and execution of marketing plans. He also concluded that the industry was willing to contribute significantly to the financing of marketing activities in return for being able to participate in the design and execution of those activities.

[Translation]

His major recommendation was the creation of the Canadian Tourism Commission, with a board of directors representing all stakeholders.

pays par voie aérienne avait eu un effet négatif sur les marchés naissants de l'Asie et les marchés établis des Amériques et en Europe. Après un boom dans la construction immobilière au cours des années 80, le Canada avait trop d'installations touristiques pour une demande en baisse, avec pour conséquence un faible rendement du capital investi.

Tous les paliers de gouvernement avaient restreint leur appui à l'industrie — au niveau fédéral, cet appui était passé de 35 millions de dollars annuellement dans les années 80 à 15 millions de dollars en 1992-1993.

[Français]

Ces facteurs sont en partie responsables des grosses pertes d'exploitation enregistrées par l'industrie hôtelière et celle du transport aérien.

[Traduction]

Comme le sénateur Callbeck l'a rappelé aux honorables sénateurs dans sa déclaration de juin sur le projet de loi, avant la création de la Commission, les efforts déployés au Canada pour faire valoir le pays comme une destination touristique étaient fractionnés entre de nombreux agents — le gouvernement fédéral, les gouvernements provinciaux et territoriaux et l'industrie touristique elle-même. N'ayant pas voix au chapitre au niveau des principes directeurs, l'industrie n'était pas disposée à former des partenariats avec le gouvernement fédéral. Par conséquent, il n'y avait aucun programme coordonné de marketing et de développement de produits, ce qui entravait encore plus l'essor du secteur. En 1992, le déficit du tourisme avait atteint près de 6 milliards et demi de dollars annuellement. Cette somme équivalait presque au quart du déficit du compte courant du Canada et le gouvernement précédent et le gouvernement actuel n'y ont certes pas été indifférents.

[Français]

C'est alors que le premier ministre a décidé de nommer l'honorable Judd Buchanan au poste de conseiller spécial en tourisme et l'a chargé de recommander les mesures à prendre pour accroître les recettes touristiques, créer des emplois dans le secteur et réduire le déficit du poste «voyages».

[Traduction]

Après avoir mené des consultations dans l'ensemble de l'industrie, M. Buchanan a conclu que ce qui faisait défaut, c'était une structure permettant à tous les intervenants de contribuer à l'élaboration et à la mise en oeuvre des plans de marketing. Il a également constaté que l'industrie était disposée à contribuer de façon substantielle au financement des activités de marketing si on lui offrait, en contrepartie, la possibilité de participer à la conception et à la mise sur pied de ces activités.

[Français]

Sa recommandation principale était la création de la Commission canadienne du tourisme, dirigée par un conseil d'administration représentant tous les intervenants.

[English]

The greatest advantage of the new commission would be the participation of industry as full partners in jointly developed and jointly funded programs. Through this participation, the commission would become the catalyst for industry cooperation and collaboration, thereby overcoming one of the major flaws of past efforts.

When we look at the accomplishments of the tourism industry in Canada after only five years' experience with the commission, the statistics are indeed very impressive. Naturally we cannot say that the commission is responsible for the complete turnaround in the industry, because that has largely come from the hard work of the people who deliver the products, and, obviously, from a worldwide, positive improvement in economic conditions in major tourism markets. However, the commission has directly helped to create a climate of working together at all levels. It has served as a spark and catalyst for cooperative marketing and for new products based on sound research and analysis. It has served as a focus for debate, for industry intelligence, and for level-headed strategizing.

Comparing 1999 figures with those for 1995, just before the commission was established...

[Translation]

Tourism is now a leading growth sector in the economy, generally rising faster than the growth of the Gross Domestic Product.

[English]

Total tourism revenue for 1999 was more than \$50 billion — up by 25 per cent since 1995. The travel deficit has decreased to \$1.7 billion — down nearly 50 per cent from \$3.3 billion in 1995. Tourism is producing new employment at a faster rate than the overall business sector.

[Translation]

Domestic tourism has increased by 20 per cent, which also helps to reduce the travel-account deficit.

[English]

We have improved our standing in the fiercely competitive international tourist market, moving up from 11th to 7th place as a tourism destination according to the World Tourism Organization.

As for the commission itself, the latest third-party evaluation from Price Waterhouse came to some telling and, I am pleased to say, very favourable conclusions. There was consensus among the partners that they were now able to do things that would not otherwise be deemed affordable, and they felt that being associated with the commission gave them broader audience coverage and broader exposure geographically.

[Traduction]

L'atout principal de la nouvelle Commission serait la participation des représentants de l'industrie en tant que partenaires de plein droit, et l'élaboration et le financement conjoints des programmes. Forte de cette participation, la Commission pourrait servir de catalyseur facilitant la coopération et la collaboration de l'industrie, corrigeant ainsi l'une des grandes lacunes des efforts déployés dans le passé.

Si l'on se penche sur les réalisations du secteur touristique au Canada — seulement cinq ans après la création de la Commission —, les résultats sont impressionnants. Il n'est évidemment pas question d'affirmer que la Commission est à elle seule responsable d'un revirement de l'industrie — cette évolution est en grande partie attribuable au travail acharné des gens qui mettent les produits sur le marché et à une conjoncture plus favorable dans nos principaux marchés touristiques. Cependant, la Commission a participé directement à l'instauration d'un climat de collaboration à tous les niveaux. Elle a été une source d'inspiration et un catalyseur pour le marketing en coopération et pour la création de nouveaux produits fondés sur la recherche et des analyses solides. Elle a servi de point de convergence des discussions, des renseignements sur l'industrie et de stratégies sensées.

Si l'on compare les chiffres de 1999 à ceux de 1995, juste avant la création de la Commission...

[Français]

Le tourisme est maintenant l'un des principaux secteurs de croissance de l'économie et il progresse, de façon générale, à un rythme plus rapide que le produit intérieur brut.

[Traduction]

En 1999, les recettes touristiques totales se chiffraient à plus de 50 milliards de dollars, soit une augmentation de 25 p. 100 par rapport à 1995. Le déficit du poste «voyages» a été ramené à 1,7 milliard de dollars, ce qui représente une diminution de près de 50 p. 100 par rapport au déficit de 3,3 milliards de dollars enregistré en 1995. Le tourisme crée de nouveaux emplois plus vite que l'ensemble du secteur commercial.

[Français]

Le tourisme intérieur a progressé de 20 p. 100, ce qui a également permis de réduire le déficit du poste «voyages».

[Traduction]

Malgré une concurrence internationale féroce, nous avons grimpé sur le marché touristique mondial de la onzième à la septième place, selon l'Organisation mondiale du tourisme.

Pour ce qui est de la Commission, la plus récente évaluation effectuée par un organisme tiers, Price Waterhouse, a tiré plusieurs conclusions éloquentes et, j'ai le plaisir de le dire, très flatteuses. Les partenaires sont d'accord sur le fait qu'ils peuvent maintenant entreprendre des choses qu'ils n'auraient autrement pas les moyens de faire et ils estiment que leur association avec la Commission leur donne accès à un public plus large et à une couverture géographique plus étendue.

They are better able to leverage existing dollars, and they are able to be involved both in media and in programs that they could not normally afford. The commission has created a climate where competitors can make a larger impact in a market by jointly taking their products into that market.

[Translation]

The commission's efforts have created a heightened presence and awareness for Canada in international markets.

[English]

Association with the commission lends credibility to product offerings and less well-known organizations, and smaller firms benefit from the commission's resources in marketing intelligence and research, marketing and media expertise, and human resources.

The final point I wish to raise is the commission as a Crown corporation. The commission has certainly earned its stripes over its short history as a special operating agency. I should like to conclude with some observations on why the time is right for the proposed legislation before you to establish the commission as a Crown corporation. When the commission was formed, the Prime Minister urged the organization to get up to speed and move quickly. The fastest way to do that without missing a year in the market was to form a special operating agency.

[Translation]

The board and the Minister of Industry, the Honourable John Manley, recognize that this was never a final decision. It was simply the best way to get going.

[English]

With five years of operations behind it, the commission now needs much more financial and strategic flexibility if it is going to respond to the needs of an ever-changing marketplace, and if it is to continue to be a truly effective partner as tourism grows in Canada.

Current federal legislation governing departments and special operating agencies such as our commission places substantial limitations on what can be done. There are limits on entering into contracts, on partnerships, and on managing finances and human resources. The only way around these limitations is to make the commission a Crown corporation that will have the legal mandate to operate more effectively, efficiently, and with greater flexibility.

The commission does not own or operate tourism facilities. It is a marketing agency and, as such, it needs to use modern, streamlined business practices to enter into partnership contracts and manage funds for joint undertakings. It needs the authority to keep funds year over year. Although there are administrative means of rolling over some money from year to year, these methods are cumbersome for the commission; its needs would be better met, in our opinion, as a Crown corporation. It needs authority to keep the revenues that it makes through merchandising. These revenues currently become part of the

Ils sont plus à même de rentabiliser leur investissement et peuvent participer à des activités médiatiques et à des programmes qui coûteraient normalement trop cher. La Commission a créé un climat qui permet à des entreprises concurrentes de regrouper leurs produits pour avoir de meilleurs résultats sur les marchés.

[Français]

Grâce aux efforts de la Commission canadienne du tourisme, le Canada est plus présent et mieux connu sur les marchés étrangers.

[Traduction]

Le fait d'être associé à la Commission confère de la crédibilité aux produits et aux organisations moins connues et les petites entreprises bénéficient des ressources de la Commission en matière de renseignements commerciaux et de recherche, de ses compétences en marketing, en relations avec les médias et en gestion des ressources humaines.

La Commission en tant que société d'État est le dernier point que j'aimerais aborder. La Commission a sans aucun doute gagné ses galons pendant sa courte existence en tant qu'organisme de service spécial. J'aimerais maintenant conclure avec quelques observations qui montrent pourquoi il est opportun d'adopter le texte de loi devant vous, qui fera de la Commission une société d'État. Lorsque la Commission a été créée, le premier ministre l'a exhortée à s'organiser et à agir sans attendre. Le moyen le plus rapide pour y parvenir, sans perdre une année sur le marché, consistait à mettre sur pied un organisme de service spécial.

[Français]

Le conseil d'administration et le ministre de l'Industrie, l'honorable John Manley, savaient que ce n'était pas une décision définitive mais simplement la meilleure façon de démarrer.

[Traduction]

Après cinq années d'activité, la Commission doit aujourd'hui disposer d'une marge de manoeuvre financière et stratégique beaucoup plus grande pour réagir aux besoins du marché et pour demeurer un partenaire efficace, alors que le secteur du tourisme continue de croître au Canada.

Les lois fédérales qui régissent actuellement les ministères fédéraux et les organismes de service spécial, tels que la Commission, limitent fortement la marge d'action de ces organismes. Ceux-ci sont en effet limités pour ce qui a trait à la passation de contrats, aux partenariats et à la gestion des finances et des ressources humaines. La seule façon d'affranchir la Commission de ces contraintes consiste à en faire une société d'État, dotée par la loi d'un mandat prévoyant un fonctionnement plus efficace, plus efficient et plus souple.

La Commission ne possède ou n'administre aucun établissement touristique. C'est un organisme de marketing. À ce titre, elle doit pouvoir fonctionner en s'appuyant sur des méthodes commerciales modernes et rationalisées afin de pouvoir conclure des contrats de partenariat et gérer les fonds aux fins de la réalisation de projets conjoints. Elle doit également disposer de l'autorité voulue pour reporter ses fonds d'une année à l'autre. Bien qu'il existe des moyens administratifs de le faire, ces méthodes sont peu pratiques pour la Commission et le statut de société d'État offre à cette fin la meilleure solution. La

government's Consolidated Revenue Fund, when they could be reinvested in tourism marketing programs.

The commission needs authority to open bank accounts, including local accounts in foreign countries to pay locally engaged staff and marketing contractors. Under current restrictions, these accounts can only be paid either through the Department of Foreign Affairs and International Trade, or by cheques on Canadian accounts in Canadian funds, which can lead to delays at some foreign banks.

I scarcely need to emphasize that the essence of the Canadian Tourism Commission's success lies in its ability to form partnerships between the private sector and governments. All provinces and territories, and hundreds of businesses, have joined forces with the commission over the years.

[Translation]

Private and public sector partners have contributed so significantly to the financing of the commission's activities that the original projections for their contributions consistently exceeded the federal government's core funding.

[English]

The private-sector component of the commission remains at the core of its operations. Private-sector-led committees are responsible for individual program areas.

I should like to mention, Mr. Chairman, that the private sector and the commission's board of directors support this proposed legislation. If adopted, it will mean that Treasury Board will no longer have to create special, precedent-setting instruments for the commission to conduct its business.

Tourism is of great significance to each of the provinces and territories, and to most large cities and smaller rural communities. It is, of course, of primary concern to the thousands of investors and operators and the more than 500,000 Canadians who work in this sector. Because tourism is of such critical importance to these people and to other governments, Crown corporation status will make the commission one of the pivotal partners in the industry — the partner that has the mandate, the means, and the resources to contribute to the overall well-being of the entire industry for the benefit of all Canadians.

As president of the Canadian Tourism Commission, I am looking forward to this evolution in its affairs and to the positive contributions that the commission will continue to make as a catalyst for jobs and economic growth in an expanding and important sector of our economy.

My officials and I would be delighted to answer any questions you may have.

Commission doit pouvoir conserver les recettes qu'elle perçoit pour ses activités de marchandage. À l'heure actuelle, ces recettes sont versées au Trésor du Canada, alors qu'elles pourraient être réinvesties dans des programmes de marketing touristique.

Elle doit pouvoir ouvrir des comptes en banque, y compris des comptes locaux dans des pays étrangers afin de payer les employés qu'elle engage sur place et les contractuels chargés du marketing. Or, en vertu des contraintes actuelles, ces comptes ne peuvent être réglés que par l'entremise du ministère des Affaires étrangères et du Commerce international ou par des chèques tirés sur des comptes canadiens et libellés en dollars canadiens, ce qui peut entraîner des délais dans les banques étrangères.

J'ai à peine besoin d'insister sur le fait que le succès de la Commission canadienne du tourisme repose essentiellement sur sa capacité de former des partenariats entre les administrations publiques et le secteur privé. Les provinces, les territoires et des centaines d'entreprises ont uni leurs efforts à ceux de la Commission.

[Français]

Les partenaires des secteurs public et privé ont contribué de façon appréciable au financement des activités de la Commission canadienne du tourisme. En fait, leurs contributions ont constamment excédé le financement de base du gouvernement fédéral.

[Traduction]

Le volet secteur privé de la Commission demeure au cœur de ses opérations. Ce sont des comités dirigés par le secteur privé qui sont responsables des programmes.

Monsieur le président, j'aimerais mentionner que le secteur privé et le conseil d'administration de la Commission sont en faveur du projet de loi. Si le projet est adopté, le Conseil du Trésor n'aura plus à mettre en place des instruments spéciaux qui permettent à la Commission de mener ses activités, mais qui créent un précédent.

Le tourisme revêt une grande importance pour chaque province et territoire ainsi que pour la plupart des grandes villes, mais aussi pour de nombreuses petites localités rurales. Ce secteur est évidemment d'un intérêt crucial pour les milliers d'investisseurs et d'exploitants, et pour le demi-million au moins de personnes qu'elle emploie. Compte tenu de l'importance du tourisme pour ces personnes et pour les autres pouvoirs publics, le statut de société d'État fera de la Commission canadienne du tourisme un des acteurs essentiels de l'industrie touristique, un partenaire ayant le mandat, les moyens et les ressources nécessaires pour contribuer à la prospérité globale de l'industrie entière, dans l'intérêt de tous les Canadiens.

En tant que président-directeur général de la Commission canadienne du tourisme, je suis impatient de suivre cette évolution et de voir l'apport positif que continuera d'offrir la Commission en tant que catalyseur pour la création d'emplois et la croissance dans un important secteur en plein essor.

Les représentants de la Commission et moi-même nous ferons un plaisir de répondre à vos questions.

The Chairman: Mr. Watson, I should like to ask you one general question about the board. Aside from you and the chair, your board is comprised essentially of nine so-called "private sector" representatives and seven appointed by provincial and territorial governments.

Are the seven appointed by the provincial and territorial governments allocated regionally? Is the intention that there would be, for example, two from the Atlantic region, one from Quebec, one from Ontario, two from the West, and one from the North?

Mr. Watson: Yes, that is the principle. For instance, the current deputy minister of Tourism from P.E.I. is one representative. When we have a public-sector representative from that province, we will have a private-sector tourism operator from Nova Scotia on the board.

The Chairman: Therefore, in the Atlantic provinces, as an example, you would have two public and two private representatives, in fact one per province. You are saying that the attempt would be made to make that into one per province.

Mr. Watson: Yes. In fact we have one from each province in the Atlantic. We have the deputy ministers of Tourism from Newfoundland and P.E.I., and a private-sector operator from each of New Brunswick and Nova Scotia.

The Chairman: Of the nine private-sector representatives, seven are regionally allocated and two are not. What kind of people fit that criteria?

Mr. Watson: One of the individuals is the president of Inniskillen Wines from Ontario. We have representatives from both non-scheduled and scheduled airlines. There is currently a vacancy on the Air Canada seat.

Senator Banks: Air Canada has a vacant seat?

The Chairman: Obviously you do not fly as much as we do. There is no such thing as a vacant seat on any Air Canada plane these days. That is a subject for another committee.

Senator LeBreton: Mr. Watson, may I congratulate you on your appointment. Certainly those of us from the Ottawa area know full well of your tireless enthusiasm and your extreme commitment to anything you undertake.

Will you outline exactly how you will work with the private sector? How will you prevent a situation of "who's on first," so to speak? Perhaps some organizations in the private sector will think that they do not have to move into a certain area because they envisage that the Canadian Tourism Commission will handle that specific area and will promote tourism. How will you sort out, among your organization, the provinces, and the private sector, the responsibilities that each will have?

Mr. Watson: We have had tremendous success in attracting the private sector to the table for a couple of reasons. Primarily, we have been able to give them a meaningful role in the decision-making process. Over half of our board is from the

Le président: Monsieur Watson, j'aimerais d'abord vous poser une question d'ordre général au sujet du conseil. Mis à part vous et le président, le conseil se compose essentiellement de neuf représentants dits du «secteur privé» et de sept représentants nommés par les gouvernements provinciaux et territoriaux.

Est-ce que les sept représentants nommés par les gouvernements provinciaux et territoriaux sont choisis suivant les régions? A-t-on l'intention, par exemple, de choisir deux représentants de la région de l'Atlantique, un du Québec, un de l'Ontario, deux de l'Ouest et un du Nord?

M. Watson: Oui, c'est ce qu'on a l'intention de faire. Par exemple, l'actuel sous-ministre du Tourisme de l'Île-du-Prince-Édouard agit en qualité de représentant de la région. Il y aura au sein du conseil un représentant du secteur public de cette province, et un exploitant d'une entreprise touristique du secteur privé de la Nouvelle-Écosse.

Le président: Donc, vous auriez, pour les provinces de l'Atlantique, par exemple, deux représentants du secteur public et deux du secteur privé, soit un par province. Vous dites que votre objectif est d'avoir un représentant par province.

M. Watson: Oui. En fait, nous avons un représentant de chaque province dans l'Atlantique. Il y a les sous-ministres du Tourisme de Terre-Neuve et de l'Île-du-Prince-Édouard, et un exploitant du secteur privé et du Nouveau-Brunswick et de la Nouvelle-Écosse.

Le président: Des neuf représentants du secteur privé, sept sont choisis suivant la région. Qui sont ces personnes?

M. Watson: Il y a, entre autres, le président d'Inniskillen Wines, en Ontario, et des représentants de compagnies aériennes de transport non régulier et régulier. Personne ne représente pour l'instant Air Canada.

Le sénateur Banks: Le siège d'Air Canada est vacant?

Le président: Vous ne devez pas prendre l'avion aussi souvent que nous, car des sièges vacants, il n'y en a pas ces jours-ci à bord des avions d'Air Canada. Mais c'est un sujet d'étude pour un autre comité.

Le sénateur LeBreton: Monsieur Watson, je tiens à vous féliciter pour votre nomination. Ceux, parmi nous, qui sont de la région d'Ottawa savent fort bien que vous faites preuve d'un enthousiasme débordant quand vous entreprenez un projet, et que vous vous y engagez à fond.

Comment exactement comptez-vous travailler avec le secteur privé? Comment allez-vous éviter que certains, pour ainsi dire, «ne jouent du coude»? Certains organismes du secteur privé vont peut-être penser qu'ils n'ont pas à intervenir dans un domaine en particulier parce que c'est la Commission canadienne du tourisme qui va se charger de faire la promotion du tourisme dans celui-ci. Comment allez-vous répartir les responsabilités entre votre organisation, les provinces et le secteur privé?

M. Watson: Nous n'avons eu aucune difficulté à attirer des représentants du secteur privé, et ce, pour plusieurs raisons. D'abord, nous leur avons confié un rôle déterminant dans le processus décisionnel. En effet, plus de la moitié des membres du

private sector, but more important, 100 per cent of the various committees of the CTC are made up of representatives from the private sector.

To give an example, we have committees based on our geographic marketing programs.

We have a European committee and an Asian committee. All of the people on those committees are private-sector representatives who either volunteer or sit on a committee at our request. Therefore, the decisions reached on the number of dollars spent on advertising for Europe, Asia, the U.S., or Canada are made by these committees and recommended to our board of directors. We have had fairly good success in reaching consensus among the private sector and the other public-sector partners.

The other reason, to be perfectly crass, is that we bring some money to the table. When the provinces want to conduct a marketing campaign, we can partner with them. We not only bring expertise in research and advertising, we also help by putting some federal dollars into a provincial program — for example, in Nova Scotia, Quebec, or British Columbia.

Senator LeBreton: In determining your marketing strategy for bringing tourists to Canada, what percentage is still by the so-called “rubber traffic” — coming by car or bus? Knowing that figure, is there a more targeted effort by the provinces and the private sector to go into those markets in the northern part of the United States where there are huge populations?

Mr. Watson: We will get that figure for you. The vast majority of tourism dollars spent in Canada are by Canadians travelling within their own country. Our next biggest market is, of course, the United States. We do not have the percentage right now coming from vehicle versus train or airplane.

Senator LeBreton: Do you get down to that kind of detail at the commission? Do you actually work with the private sector, or do you leave that up to it and the provinces? Are they the ones who bring that data to you, rather than your focusing in on that particular market in terms of attracting tourists to Canada?

Mr. Watson: It is a combination of efforts. We do a great deal of work with Statistics Canada on border entry data, so that we have an exact count of the number of people who come across any border. Those figures are provided to us in partnership, and we actually help fund that particular study. That material is then shared with the provinces and with the private sector, so that marketing decisions are based on research. We also have offices in, I believe, 12 countries around the world and they are providing information to us. I am proud to say we have become a leader in market research simply because we have been able to work with Statistics Canada — which is viewed as a world leader by the international community — to provide accurate information on people coming back and forth across the border. We can give you

conseil viennent du secteur privé. Plus important encore, les divers comités de la CCT sont tous composés de représentants du secteur privé.

Pour vous donner un exemple, nous avons mis sur pied des comités en fonction de nos programmes de marketing axés sur les régions géographiques.

Nous avons un comité européen et un comité asiatique, dont les membres viennent tous du secteur privé. Ils y siègent de leur plein gré ou à notre demande. Par conséquent, les décisions concernant les dépenses publicitaires pour l'Europe, l'Asie, les États-Unis ou le Canada sont prises par ces comités et soumises au conseil d'administration. Nous n'avons pas trop de difficulté à amener les partenaires des secteurs privé et public à s'entendre.

Ensuite, et je vais être très franc avec vous, nous apportons de l'argent à la table. Quand les provinces veulent entreprendre une campagne de marketing, nous collaborons avec elles. Elles bénéficient non seulement de nos compétences dans les domaines de la recherche et de la publicité, mais également des fonds fédéraux que nous investissons dans un programme provincial — par exemple, en Nouvelle-Écosse, au Québec ou en Colombie-Britannique.

Le sénateur LeBreton: Concernant la stratégie de marketing que vous avez établie pour attirer des touristes au Canada, combien de visiteurs arrivent encore par voiture ou autocar? Compte tenu de ces chiffres, est-ce que les provinces et le secteur privé ciblent davantage les marchés du Nord des États-Unis, où il y a un grand bassin de population?

M. Watson: Nous allons trouver ces chiffres. La grande majorité des recettes touristiques au Canada proviennent de Canadiens qui voyagent à l'intérieur de leur propre pays. Bien entendu, les États-Unis représentent le deuxième marché touristique en importance du Canada. Nous ne savons pas, pour l'instant, combien de personnes viennent au Canada en voiture, en train ou en avion.

Le sénateur LeBreton: Est-ce que la Commission s'intéresse à ce genre de détails? Est-ce que vous recueillez ces données de concert avec le secteur privé, ou est-ce ce dernier et les provinces qui se chargent de les compiler? Est-ce que ce sont eux qui vous fournissent ces données, ou est-ce la Commission qui concentre ses efforts sur un marché particulier afin d'attirer des visiteurs au Canada?

M. Watson: C'est un effort concerté. Nous collaborons de près avec Statistique Canada en vue de recueillir des données sur les personnes qui entrent au Canada, ce qui nous permet d'avoir une idée exacte du nombre de personnes qui franchissent les frontières. Ces chiffres nous sont fournis en partenariat. En fait, nous participons au financement de cette étude. Les données sont ensuite transmises aux provinces et au secteur privé, et les décisions de marketing sont fondées sur les résultats des recherches. Nous avons également, si je ne m'abuse, des bureaux dans 12 pays qui nous fournissent également des données. Je suis fier de dire que nous jouons un rôle de chef de file dans le domaine des études de marché, car nous avons été en mesure de travailler avec Statistique Canada — qui est considéré comme un

specific figures as to the number of people who have come from a particular country and at what time of the year. If trends develop that show that we seem to be getting a lot more people coming from Germany in July and August and they seem to be heading to the Far North, we can then analyze the reasons for that. More importantly, we can analyze the numbers such that we know when there is a decline in the number of people from a particular country and can shift our marketing dollars around.

Senator LeBreton: It is fair to say then, that you could be the leader in establishing the trends and setting the industry — private sector and the provinces — off in the right direction. You can see these trends, so you take a very strong leadership role, rather than simply reacting to suggestions or myths that they may be operating under. You can actually use the data from Statistics Canada. Hence, you set the agenda rather than react to it.

Mr. Watson: That is right. Our vice-president of marketing may want to add to that.

One point I neglected to mention was on your previous question vis-à-vis the money that we spend. Our policy is that any money we spend has to be partnered with the private sector. In fact, while the federal government provides us with \$75 million on an annual basis, last year I believe we received \$82 million in partnership — either in funds, in kind, or by joining with their marketing campaign. We are quite proud of that, and it certainly allows our \$75 million to go a lot further.

Senator Banks: I hope, Mr. President, that you are not missing being referred to as “Your Worship.”

Mr. Watson: I decided that people were starting to call me “Your Washup.”

Senator Banks: I note that the objectives include sustaining a vibrant and profitable Canadian tourism industry. I assume that a large part of that is through marketing. I also assume that you may have had a chance to read the provisions of Bill C-27, the national parks bill, and some of the arguments and motivations that have led to the new definition of “ecological integrity.” You may have heard reservations from some people, some of whom are on your board I suspect, about whether or not you will have anything to market. That is an exaggeration, but I would like to refer you to the report of the minister’s Panel on the Ecological Integrity of Canada’s National Parks, which recommends that Canada immediately cease the product marketing of national parks in general, and the product marketing which attempts to increase overall use of parks or divert demands to so-called “under-used” parks in particular, and concentrate instead on social marketing, policy marketing, and “de-marketing” aimed at an appropriate target audience.

leader mondial par la communauté internationale — et de fournir des renseignements précis sur le nombre de personnes qui traversent la frontière. Nous pouvons vous dire de façon précise combien de personnes viennent d’un pays particulier, et à quel moment de l’année. Si nous constatons que nous accueillons beaucoup plus de visiteurs de l’Allemagne en juillet et en août et que ceux-ci semblent se diriger vers le grand Nord, nous pouvons procéder à une analyse de la situation. Plus important encore, nous pouvons, en analysant les chiffres, déterminer à quel moment le nombre de visiteurs en provenance d’un pays en particulier est à la baisse, et modifier notre stratégie de marketing en conséquence.

Le sénateur LeBreton: Il n’est donc pas exagéré de dire que vous pourriez assumer un rôle de leadership en analysant les tendances et en montrant à l’industrie — le secteur privé et les provinces — la voie à suivre. Vous voyez les tendances qui s’établissent, et vous assumez un rôle déterminant au lieu de tout simplement réagir aux suggestions ou aux mythes qui sont véhiculés. Vous pouvez en fait utiliser les données de Statistique Canada. Vous établissez la marche à suivre au lieu d’y réagir.

M. Watson: C’est exact. Le vice-président du marketing aurait peut-être quelque chose à ajouter à ce sujet.

J’ai oublié de mentionner un point quand j’ai répondu à votre question sur les dépenses. Nous partons du principe que les dépenses que nous effectuons doivent être faites en partenariat avec le secteur privé. Bien que gouvernement fédéral nous octroie environ 75 millions de dollars par année, l’an dernier, nous avons recueilli, si je ne m’abuse, grâce à ce partenariat, 82 millions de dollars — que ce soit sous forme de fonds, de paiements en nature, ou en participant à des campagnes de marketing. Nous en sommes très fiers, puisque cela nous permet de faire plus avec nos 75 millions de dollars.

Le sénateur Banks: J’espère, monsieur le président, que vous ne regrettez pas trop votre poste de maire.

M. Watson: Je trouvais que les gens commençaient à croire que j’étais dépassé.

Le sénateur Banks: Je note que la Commission a pour mission, entre autres, de veiller à la prospérité et à la rentabilité de l’industrie canadienne du tourisme. Je présume qu’elle aura surtout recours au marketing pour y arriver. Je présume aussi que vous avez eu l’occasion de lire les dispositions du projet de loi C-27, qui concerne les parcs nationaux, et d’entendre certains des arguments qui ont abouti à la nouvelle définition de l’«intégrité écologique». Vous avez sans doute entendu les réserves qui ont été formulées, dont certaines par des membres de votre conseil, au sujet de la question de savoir si vous aurez quelque chose à commercialiser. Je trouve ces propos exagérés, mais j’aimerais vous citer le rapport de la Commission sur l’intégrité écologique des parcs nationaux du Canada, qui recommande que Parcs Canada mette fin au marketing des parcs comme des produits de consommation, de même qu’à celui ayant pour but d’accroître l’utilisation globale des parcs ou de faire dévier la demande au profit des parcs dits «sous-utilisés», et qu’il concentre plutôt ses efforts sur le marketing social, le marketing de politique et le «démarketing» en ciblant les auditoires appropriés.

The report further states that the people learn about national parks and national historic sites in many different ways, and fortunately visiting them is no longer the only way to experience their sights and sounds.

I am wondering about the left hand and the right hand here. I do not think the minister actually intends to start denuding the western national parks of their attractions — accommodations and so on. If such is the case, however, what would be your attitude, and what would be your board's attitude, to the idea of de-marketing — convincing people not to come here?

Mr. Watson: As a marketing agency, we obviously would not support that philosophy — an entire de-marketing of the national parks system. For years, for decades in fact, the parks have acted as a magnet, not just for foreign visitors, but for Canadians as well. That is very important to the tourism fabric of this country.

We were very proud of the fact that just last week, the U.S. edition of *Time* had a two-page article on ecotourism, focusing primarily on British Columbia, but also on Algonquin Park. I suspect that at some point we will be asked for our position. There is no question that it is a divisive issue in the community. There are those who subscribe to the view that parks should be seen and not trampled on. Yet the parks community employs literally tens of thousands of people, and the spin-off — whether it is Banff or Jasper — is very important to the economy of those parts of the country. I suspect our board, if formally asked to take a position, would not be supportive of discouraging people from visiting the parks.

Senator Banks: I know that no one in his/her right mind wants to trample on the parks. Everyone who has ever been to our national parks recognizes that certain of them have become "overdeveloped." No one likes that, least of all me. Perhaps there needs to be some de-marketing, but I am wondering about the tension that might develop. I guess I am asking you for a personal opinion.

If it were to become the policy of Parks Canada to, at the very least, de-emphasize marketing, or actually de-market, to reduce traffic within some areas of the national parks, how would the tension between that and the interests of your board be resolved?

Mr. Watson: We might have to go to the UN for mediation because it would be a very divisive issue. I would like to ask Mr. Wheelock, our vice-president of marketing, to comment, because obviously, as I indicated, when a marketing organization such as ours hears the word "de-market," we have concerns about that.

Mr. Roger Wheelock, Vice-President, Marketing, Canadian Tourism Commission: Yes, it is a very challenging issue for us, but we are actually working with Parks Canada at the moment. They have various mandates, one of which is ecological integrity, which is supremely important to the preservation of that wonderful resource of ours. However, they have other mandates as

Le rapport précise en outre que les gens sont informés au sujet des parcs nationaux et des lieux historiques nationaux de toutes sortes de façons et que, fort heureusement, se rendre sur place n'est plus la seule manière de se familiariser avec leurs panoramas et leurs environnements sonores.

Je me pose des questions au sujet de la main gauche et de la main droite. Je ne crois pas que le ministre ait l'intention de commencer à dépouiller les parcs nationaux de l'Ouest de leurs attractions — installations et autre chose du genre. Toutefois, si c'était le cas, comment réagiriez-vous? Comment réagirait le conseil à l'idée de recourir au démarketing — le fait de convaincre les gens de ne pas venir ici?

M. Watson: En tant qu'organisme de marketing, nous rejeterions ce concept — le démarketing du réseau des parcs nationaux. Pendant des années, en fait pendant des décennies, les parcs ont servi à attirer non seulement les visiteurs étrangers, mais également les Canadiens, ce qui est très important pour l'industrie touristique canadienne.

Nous sommes très fiers du fait que, la semaine dernière, l'édition américaine de la revue *Time* comportait un article de deux pages sur l'écotourisme qui se pratiquait surtout en Colombie-Britannique, mais aussi dans le Parc Algonquin. Je présume qu'à un moment donné, on va nous demander de prendre position là-dessus. C'est une question qui divise indubitablement la collectivité. Certains soutiennent que les parcs devraient être admirés de loin. Or, les parcs emploient littéralement des dizaines de milliers de personnes, et les retombées — qu'il s'agisse de Banff ou Jasper — apportent beaucoup à l'économie de ces régions. Le conseil, si on lui demandait de se prononcer officiellement sur la question, ne serait pas d'accord avec l'idée de décourager les gens de visiter les parcs.

Le sénateur Banks: Aucun être sensé n'oserait endommager les parcs. Tous ceux qui ont visité nos parcs nationaux reconnaissent que certains d'entre eux sont «surdéveloppés». Personne n'aime cela, surtout pas moi. Il faut peut-être avoir recours au démarketing, mais je me pose des questions au sujet des conflits que cela créerait. Je suppose que je vous demande de me donner votre avis là-dessus.

Si Parcs Canada décidait d'avoir recours, à tout le moins, au démarketing pour réduire le nombre de visiteurs dans certaines parties des parcs nationaux, comment arriveriez-vous à concilier cette démarche avec les intérêts de votre conseil?

M. Watson: On serait peut-être obligé de faire appel à un médiateur de l'ONU parce que cette question entraînerait la division. J'aimerais demander à M. Wheelock, le vice-président du marketing, de nous dire ce qu'il en pense parce que, comme je l'ai déjà mentionné, quand un organisme de marketing comme le nôtre entend le mot «démarketing», cela soulève chez lui des inquiétudes.

M. Roger Wheelock, vice-président, Marketing, Commission canadienne du tourisme: Oui, cette question constitue pour nous un véritable défi, mais nous collaborons pour l'instant sur ce point avec Parcs Canada. Son mandat consiste, entre autres, à assurer le maintien de l'intégrité écologique, qui est essentielle à la préservation de cette merveilleuse ressource.

well. Commemorative integrity is important. One of the attributes of Canada is an authentic travel experience, and that is recognized worldwide. The parks are our icons.

We must be sensitive to the issue of overuse in the parks, particularly in the high season in the main icon parks. We are also working with Parks Canada, perhaps not to de-market, but to market in a more sensitive way. We want to use the idea of learning travel, which is a very "hot" travel motivator at the moment, to communicate that we do not wish to cease marketing the parks, but to market them to an audience that will be appreciative and respectful of them, in order to assure their continuity.

That issue is not exclusive to parks, where it tends to be the focus because of their fragility, but extends also to national historic sites. Some of those, in addition to more focused marketing, will be advantaged by a broader marketing effort across all seasons as well.

Part of our issue in marketing parks is the length of time they stay open. Perhaps if we could keep them and some of our historic sites open longer, we could spread the load a little better, to the benefit of everyone, and respond to our four-season mandate for marketing Canada generally.

Senator Banks: Such marketing may be compatible, even in the mountain parks, which are already open 365 days a year.

I would like to bring to your attention the remarkable statistics on people who come to Canada specifically to attend cultural events. I urge you to take advantage of that. Although most Canadians do not know this, Canada has become a magnet for people wishing to attend cultural events of all kinds. I hope that cultural marketing will be an important and integral part of your efforts worldwide.

Mr. Watson: I agree with you wholeheartedly, senator. We have a subcommittee on cultural tourism at the Canadian Tourism Commission. In fact I was informed by one of our staff only last week that the Federation of Canadian Municipalities, an organization with which I used to deal, is also very interested in promoting culture as a tourism tool, be it through festivals such as the International Jazz Festival in Montreal, or here in Ottawa. Particularly with an aging population, more time and money are being spent on that. Our partners see the benefit of it as well.

I found the statistics for which Senator LeBreton was asking. The number of trips by non-residents from the United States by automobile to June 1999 was 3.6 million. That compares to 475,000 by plane; 218,000 by bus; and 227,000 by rail, boat, and other methods. I am not sure what "other methods" are.

Toutefois, Parcs Canada a également d'autres mandats, dont celui qui consiste à commémorer cette intégrité écologique. Le Canada offre aux visiteurs la possibilité de vivre des expériences uniques, et cet attribut est reconnu partout dans le monde. Les parcs constituent pour nous un emblème.

Nous devons éviter de surutiliser les parcs, surtout les parcs principaux, notamment pendant la haute saison. Nous collaborons avec Parcs Canada dans le but de pratiquer un marketing plus raisonnable. Nous voulons mettre l'accent sur les voyages d'apprentissage, qui sont fort populaires pour l'instant, dans le but non pas d'éliminer le marketing des parcs, mais de cibler un auditoire qui saura les respecter et assurer leur pérennité.

Cette question ne concerne pas uniquement les parcs, étant donné que nous avons tendance à diriger notre attention sur ceux-ci en raison de leur fragilité, mais également les sites historiques nationaux. Certains de ces sites tireront parti d'un marketing plus ciblé, mais aussi d'un marketing plus vaste qui s'étend sur toutes les saisons.

Une partie du problème tient à la période d'ouverture des parcs. Si les parcs et certains de nos sites historiques restaient ouverts plus longtemps, nous pourrions mieux répartir la charge, au profit de tout le monde, et, conformément à notre mandat, faire du marketing sur quatre saisons.

Le sénateur Banks: Cette démarche pourrait être efficace, même dans les parcs des Rocheuses, qui sont déjà ouverts 365 jours par année.

J'aimerais attirer votre attention sur des statistiques impressionnantes concernant le nombre de personnes qui viennent au Canada dans le but de participer à des manifestations culturelles. Je vous encourage à tirer parti de cette situation. Même si la plupart des villes canadiennes ne le savent pas, le Canada attire des gens qui souhaitent participer à des manifestations culturelles de tout genre. J'espère que le marketing culturel fera partie intégrante des efforts que vous déploierez à l'échelle mondiale.

M. Watson: Je suis tout à fait d'accord avec vous, sénateur. Il existe un sous-comité sur le tourisme culturel au sein de la Commission canadienne du tourisme. En fait, un des membres du personnel m'a indiqué, la semaine dernière, que la Fédération canadienne des municipalités, un organisme que je connais, souhaite vivement promouvoir la culture comme outil touristique, que ce soit par le biais de festivals comme le Festival international de jazz de Montréal, ou celui qui se tient à Ottawa. La population vieillit de plus en plus et consacre plus de temps et d'argent à ce genre d'activités. Nos partenaires sont également conscients des avantages qu'offre cette situation.

J'ai trouvé les statistiques que souhaitait avoir le sénateur LeBreton. Le nombre de voyages effectués en automobile par des non-résidents en provenance des États-Unis atteignait, jusqu'en juin 1999, 3,6 millions. Le nombre de voyages effectués en avion s'élevait à 475 000; en autocar, à 218 000; en train, bateau et autres modes de transport, à 227 000. Je ne sais pas ce qu'on entend par «autres modes de transport».

Senator LeBreton: There is an incredible number coming by car or bus — 3.6 million and 218,000.

Senator Callbeck: I congratulate you, Mr. Watson, on your appointment as president.

I have three questions. A 1997 Treasury Board evaluation concluded that there was a continuing need to increase small-business involvement in commission programs. I raise that because in my province of Prince Edward Island, I have heard the criticism that it is very difficult for small-business tourist operators to become involved in any way with the commission.

What work has been done since 1997 in that regard?

Mr. Watson: A couple of things have been done. First, our board recognized the importance of the small/medium enterprises, the SMEs as we call them, in the tourism industry, because they represent the substantial majority of business opportunities in tourism in this country. As a result, the board has established a permanent SME committee made up of representatives from that sector. They are in fact bringing forward a report to our next board meeting, which will take place in October in Moncton, with a series of recommendations and suggestions on how we can improve our ability to help small and medium enterprises.

We have also developed a computer system called CTX which allows primarily small businesses to partner with each other. It is a national network that has received very positive reviews from the small and medium enterprise community.

We also strive to have small- and medium-enterprise representatives on every marketing committee of the board. We have, for instance, as I mentioned, the deputy minister of Tourism from Prince Edward Island, who is certainly well aware of your constituents' concerns, to try to make us more responsive in the future. I think we have done some tangible things to deal with that.

It is a very difficult challenge. For example, the priorities of a large multinational or national hotel chain are substantially different from those of a bed and breakfast or small marina operator. We must be sensitive to those concerns. We are trying to feature more articles on SMEs in our newsletter, *Communiqué*, which is distributed to 24,000 businesses. We also have "product clubs," which is a new innovation that allows small businesses to come together and see how they can partner. For instance, the wine industries in the Okanagan and in the Niagara region of Ontario have developed a product club so that the small wineries can get together and work with the Canadian Tourism Commission to market wine tours. The golf industry, which is very important to Prince Edward Island, is another product club. Small golf courses could not afford to market properly on their own, but working in tandem, and together with the CTC, they can.

Le sénateur LeBreton: Ils sont incroyablement nombreux à venir en voiture ou en autocar — 3.6 millions et 218 000.

Le sénateur Callbeck: Je vous félicite, monsieur Watson, pour votre nomination en tant que président.

J'ai trois questions à poser. Une évaluation du Conseil du Trésor datée de 1997 a permis de conclure qu'il fallait continuer à accroître la participation des petites entreprises aux programmes de la Commission. Si je soulève ce point, c'est parce que dans ma province de l'Île-du-Prince-Édouard, j'ai entendu dire qu'il est très difficile pour les petits exploitants d'entreprises touristiques de participer de quelque façon que ce soit aux travaux de la Commission.

Quels efforts ont été déployés depuis 1997 à cet égard?

M. Watson: Plusieurs choses ont été faites. Tout d'abord, notre conseil d'administration a reconnu l'importance des petites et moyennes entreprises — les PME — dans l'industrie du tourisme, parce qu'elles représentent la grande majorité des possibilités d'affaires dans le domaine du tourisme dans notre pays. Par conséquent, le conseil a créé un comité PME permanent composé de représentants de ce secteur. Ils doivent d'ailleurs nous présenter un rapport lors de la prochaine réunion du conseil, qui doit se tenir à Moncton, en octobre, ainsi qu'une série de recommandations et de suggestions sur la façon dont nous pouvons améliorer l'aide à apporter aux petites et moyennes entreprises.

Nous avons également mis au point un réseau informatique, appelé CTX, qui permet essentiellement aux petites entreprises d'établir des partenariats entre elles. C'est un réseau national qui a été très bien accueilli par les petites et moyennes entreprises.

Nous nous efforçons également d'avoir des représentants des petites et moyennes entreprises au sein de chaque comité de marketing du conseil. Nous avons, par exemple, comme je l'ai déjà dit, le sous-ministre du Tourisme de l'Île-du-Prince-Édouard qui est certainement bien au courant des préoccupations de vos électeurs, et qui peut nous aider à mieux réagir dans l'avenir. Je crois que nous avons pris des mesures concrètes à cet égard.

C'est un défi très difficile à relever. Par exemple, les priorités d'une grande chaîne hôtelière multinationale ou nationale sont profondément différentes de celles d'un propriétaire de chambres d'hôtes ou de l'exploitant d'une petite marina. Nous devons être sensibles à ces préoccupations. Nous essayons de publier plus d'articles sur les PME dans notre bulletin, *Communiqué*, qui est distribué à 24 000 entreprises. Nous avons également des «clubs de produits», innovation qui permet aux petites entreprises de s'unir et de voir comment elles peuvent créer des partenariats. Par exemple, l'industrie vinicole de l'Okanagan et de la région du Niagara, en Ontario, ont mis au point un club de produit pour que les petits établissements vinicoles puissent s'unir et travailler avec la Commission canadienne du tourisme afin de commercialiser des excursions vinicoles. L'industrie du golf, très importante pour l'Île-du-Prince-Édouard, est un autre club de produit. Les petits terrains de golf ne pourraient pas à eux seuls assurer une bonne commercialisation, alors qu'ils peuvent le faire lorsqu'ils travaillent en tandem et avec la CCT.

Senator Callbeck: Mr. Watson, you mentioned having small business represented on the committees. One of the concerns that I heard expressed was the fact that the representatives are asked to serve on committees but their travelling expenses are not covered. I asked members of the commission about that when I was briefed on this bill. The explanation I received was that according to the guidelines for CTC working committees — approved by the CTC Board of Directors, October 1997 — “At the discretion of the committee Chair, committee members may be reimbursed for direct travel expenses to attend committee meetings.”

Why would it not be policy that they be paid?

Mr. Watson: Well, it is primarily a cost factor. I met with the Nova Scotia Tourism Association and the deputy minister of Tourism two weeks ago, and they raised the issue. The SME committee that is coming forward in October to our board for discussion has also raised the matter. The Nova Scotia government is beginning to subsidize the costs for Nova Scotians who are on committees, so that they can have a voice around the table.

There is no question that it is a difficult issue for us simply because the small and medium enterprises obviously do not have the kind of expense allowances that a large company does. If, for example, the president of Fairmont Hotels wants to go to a committee meeting, he does not have to think long and hard about it, whereas for someone who runs a small bed and breakfast in Victoria, travel to a committee meeting can be a big expenditure. Thus, we try to move our committees around the country.

I know the SME members of our committee met in Whitehorse at one point and that precluded a number of people from attending simply because of the cost involved. It is one of the recommendations that the SME committee will bring forward. Our board will discuss the issue, although I cannot tell you what the outcome will be. However, I can certainly assure you that the representatives on the SME committee are very much of your opinion and your point of view.

Senator Callbeck: I notice from your statistics on major overall markets that Asia is up — the increase is 3 per cent over, for example, France. Did you spend many more dollars in Asia last year than the year before? Do these figures reflect the promotion and advertising that were done?

Mr. Watson: I will ask Roger Wheelock to comment, who will deal with the marketing. It reflects a number of other things, such as the improvement in the Asian economy. Obviously, a couple of years ago it was substantially damaged because of the so-called “Asian flu.” However, Mr. Wheelock will give you information on the marketing dollars that have gone into Asia as a result of the statistics. I believe that you are quoting from the 1999 tourism performance sheet.

Le sénateur Callbeck: Monsieur Watson, vous avez dit que vous avez des représentants des petites entreprises au sein des comités. Un des problèmes qui se posent à cet égard, c’est que l’on demande aux représentants de siéger au sein de ces comités, alors que leurs frais de déplacement ne sont pas remboursés. J’ai déjà posé la question aux membres de la Commission au moment où l’on m’a renseignée au sujet de ce projet de loi. D’après l’explication que j’ai reçue, selon les lignes directrices des comités de la CCT — approuvées par le conseil d’administration de la CCT, en octobre 1997 — c’est à la discrétion du président du comité que les membres du comité peuvent être remboursés pour leurs frais de déplacement en vue de participer aux séances de comité.

Pourquoi la politique ne prévoit-elle pas de les rembourser?

M. Watson: Eh bien, c’est avant tout une question de coût. La Nova Scotia Tourism Association et le sous-ministre du Tourisme que j’ai rencontrés il y a deux semaines ont soulevé ce point. Le comité PME qui vient rencontrer en octobre notre conseil a également posé la question. Le gouvernement de la Nouvelle-Écosse commence à subventionner les Néo-Écossais qui siègent au sein des comités, pour qu’ils puissent avoir voix au chapitre.

C’est sans aucun doute une question difficile pour nous, simplement parce que les petites et moyennes entreprises n’ont évidemment pas le même genre d’allocations pour frais qu’une grande société. Si, par exemple, le président de Fairmont Hotels souhaite se rendre à une séance de comité, il n’a pas à y réfléchir à deux fois, tandis que pour le petit propriétaire de chambres d’hôtes à Victoria, se rendre à une séance de comité peut représenter une grosse dépense. C’est la raison pour laquelle nous essayons d’avoir un roulement et de déplacer nos comités dans tout le pays.

Je sais que les membres de notre comité qui représentent les PME se sont réunis à Whitehorse à un moment donné, ce qui a empêché la participation de plusieurs personnes, uniquement à cause du coût. C’est une des recommandations que le comité PME va présenter. Notre conseil débattrait de la question, mais je ne peux pas vous dire quel en sera le résultat. Toutefois, je peux certainement vous assurer que les représentants du comité PME partagent votre point de vue.

Le sénateur Callbeck: D’après vos statistiques sur les grands marchés, la part de l’Asie a augmenté — cette augmentation dépasse de 3 p. 100 celle de la France, par exemple. Avez-vous dépensé beaucoup plus en Asie l’année dernière que l’année précédente? Ces chiffres sont-ils le reflet de la promotion et de la publicité qui ont été effectuées?

M. Watson: Je vais demander à Roger Wheelock de répondre, au sujet du marketing. Cela reflète plusieurs autres choses, comme le redressement de l’économie asiatique. De toute évidence, il y a deux ans, elle s’était considérablement dégradée à cause de ce qu’on a appelé la «grippe asiatique». Toutefois, M. Wheelock va vous donner des renseignements sur les dépenses faites en Asie pour le marketing. Je crois que vous citez la feuille de rendement touristique de 1999.

Mr. Wheelock: Yes, the Asia meltdown hit us particularly hard, and in fact we actually pulled some funds back, but decided to maintain our presence there and redirect them, as many private businesses did, into the larger U.S. market.

We received additional funds in the past year and we put back another \$1 million into that program. Our committee chairs recommend to the board, and all the committee chairs, as Mr. Watson mentioned, are in the private sector. They recommend the allocation of the resources to each of the marketing areas, and you are right that some of the percentage growth out of Asia is particularly strong. However, it is recovering from a very damaged situation. France, on the other hand, has grown significantly, with 3 per cent growth on top of compounded growth — and the U.K. has the same growth on top of compounded growth. Those markets have been strong for some time.

Senator Keon: Mr. Watson, allow me to congratulate you. I know our country will benefit tremendously from your appointment. I think you are an excellent choice for this job.

You have already partially answered my question. I have felt for a number of years, as I participated in the organization of international scientific meetings, that there was a tremendous disconnection between the overall convention industry and the tourist industry. If a little homework had been done upfront, it would have benefited both sides a great deal. However, people come to and from these conventions and they really have not been properly canvassed as to the excitement they could experience in some areas of Canada. For example, Vancouver benefits a great deal from the boat tours and the nice countryside.

Could you comment on how you see this whole area developing a synergy, and what you might do to improve the synergy?

Mr. Watson: I will ask Mr. Wheelock to answer specifically the second part of your question.

The business of conventions is extremely important to our country and a number of the economies of, primarily, the larger cities, because they actually attract the conventions — Toronto, Vancouver, Montreal, and, to a lesser degree, other cities that do not have large convention centres. We spend approximately \$4 million, partnered with an additional \$4 million or \$5 million from the private sector, to focus on the U.S. business market. We feel that is obviously our most lucrative market, because it is the closest geographically. We try to attract people both for the business conventions and the incentive travel programs that are very lucrative in the States. Those companies offer incentives to employees or customers for product loyalty, company loyalty, and so on.

We certainly notice that convention travellers spend substantially more money in a particular city in Canada than the recreational tourist because they have expense accounts and are here on behalf of business. We find that people who do come here

M. Wheelock: Oui, le ralentissement économique en Asie nous a particulièrement touchés et en fait, nous avons retiré une partie du financement, tout en décidant de maintenir notre présence et de réorienter ce financement, tout comme beaucoup d'entreprises privées l'ont fait, vers le marché américain, plus vaste.

Nous avons reçu des fonds supplémentaires l'année dernière et avons pu réinjecter un million de dollars dans ce programme. Les présidents de nos comités font des recommandations au conseil, et tous les présidents de comité, comme l'a indiqué M. Watson, appartiennent au secteur privé. Ils recommandent l'affectation des ressources à chacune des zones de marketing et vous avez raison de dire que la croissance en Asie est particulièrement forte. Elle a toutefois connu des jours sombres et elle est en train de regagner du terrain. La part du marché français, par contre, a augmenté considérablement, 3 p. 100 en plus de la croissance composée — et le R.-U. affiche le même genre de croissance en plus de la croissance composée. Depuis quelque temps, ces marchés sont très forts.

Le sénateur Keon: Monsieur Watson, permettez-moi de vous féliciter; je sais que notre pays va tirer énormément avantage de votre nomination. À mon avis, vous êtes la personne la mieux placée pour occuper ce poste.

Vous avez déjà répondu en partie à ma question. Depuis quelques années, en tant que participant à l'organisation de rencontres internationales de scientifiques, je me suis rendu compte qu'il y avait un écart énorme entre l'industrie des congrès et l'industrie du tourisme. Si l'on avait fait un peu de travail initial, ces deux industries en seraient sorties gagnantes. Toutefois, les gens qui participent à ces congrès ne sont pas bien informés des atouts de certaines régions du Canada. Par exemple, Vancouver offre beaucoup d'excursions en bateau et la campagne environnante est très belle.

Pourriez-vous dire comment, d'après vous, on pourrait aboutir à une synergie et ce que vous pourriez faire pour améliorer une telle synergie?

M. Watson: Je vais demander à M. Wheelock de répondre à la deuxième partie de votre question, en particulier.

L'industrie des congrès est extrêmement importante pour notre pays et pour l'essor économique des grandes villes surtout, puisque ce sont elles qui attirent les congrès — Toronto, Vancouver, Montréal et, à un moindre degré, d'autres villes qui n'ont pas de grands centres des congrès. Nous dépensons près de quatre millions de dollars, assortis de quatre ou cinq millions de dollars complémentaires du secteur privé, pour le marché américain des affaires. Selon nous, c'est de toute évidence notre marché le plus lucratif, puisqu'il est géographiquement le plus proche. Nous essayons d'attirer les gens pour les congrès ainsi que pour les programmes voyages de motivation qui sont très lucratifs aux États-Unis. Ces sociétés offrent des incitatifs à leurs employés ou à leurs clients en contrepartie de leur loyauté à l'égard d'un produit, à l'égard de la société, et cetera.

Nous remarquons bien sûr que les participants à des congrès dépensent beaucoup plus d'argent dans une ville donnée au Canada que les touristes d'agrément, puisqu'ils ont des comptes de frais et voyagent pour affaires. Nous constatons que les gens

and experience the beauty, nature, efficiency, cleanliness and safety of our cities want to come back. We need to do a better job, obviously, in encouraging these people to come back with their families as vacationers after they have spent three or four days in a particular city on business.

I will ask Mr. Wheelock to speak, because he can tell you a little more about the meeting and convention incentive travel program of the Canadian Tourism Commission. We are putting more emphasis and more dollars into that particular dossier because we feel that it has growth potential.

We have some concerns about areas that do not have the facilities to accommodate large conventions — Ottawa is one of those. We are limited really to a handful of cities — Vancouver, Montreal, and Toronto — where large conventions can be held. You have been to conventions that could not be accommodated in your own home town or could not be accommodated in, perhaps, Winnipeg or another municipality simply because of a lack of facilities.

Mr. Wheelock: I think Mr. Watson has covered it, but we have capacity issues in the meeting and convention incentive travel market. Partly, we would like to, for example, do much more in the incentive realm out of Asia. However, the moment you deal with a very large convention, you not only have the infrastructure issues that Mr. Watson has mentioned, but there are only a certain number of Canadian cities that can accommodate an event such as our own showcase "Rendezvous Canada."

Our research shows that tourism is projected to continue its strong growth until the year 2010. Some cities will have a distinct challenge in providing space if they are going to remain globally competitive.

Out of Asia, for example, on the incentive market side, we have an issue of simple airline space. If there are 3,000 people expected, it is not easy for any airline to provide that number of assured spaces. For those kinds of markets, you are required to make arrangements a long time ahead. The planners simply must know in advance.

On the positive side, and speaking to Senator Callbeck's concern about the small and medium-sized enterprises, we are noticing more and more a trend toward special outdoor adventures.

We have been quite successful in using ecotourism and adventure tourism as lures to hook the smaller convention and meeting groups. We tell them that we have a great product in Canada and they should come to experience it. Thus, we have been working with the Canadian domestic leisure program, the U.S. leisure program, to use those as lures as well. I think that we are making progress on those very important fronts.

qui viennent ici et qui goûtent à la beauté, à la nature, à l'efficacité, à la propreté et à la sécurité de nos villes veulent revenir. Nous devons bien sûr faire un meilleur travail pour encourager ces gens à revenir avec leurs familles comme touristes une fois qu'ils ont passé trois ou quatre jours dans une ville pour affaires.

Je vais demander à M. Wheelock de prendre la parole, car il peut vous donner un peu plus de renseignements au sujet du programme de marketing des voyages reliés aux réunions et aux congrès de la Commission canadienne du tourisme. Nous mettons davantage l'accent sur ce dossier particulier et y affectons plus d'argent car, selon nous, il offre un potentiel de croissance.

Nous avons quelques inquiétudes au sujet des villes qui ne disposent pas des installations voulues pour accueillir des congrès importants — Ottawa étant l'une d'elles. Nous sommes vraiment limités à deux ou trois villes — Vancouver, Montréal et Toronto — où de grands congrès peuvent se dérouler. Vous êtes allé à des congrès qui ne pouvaient pas avoir lieu dans votre propre ville ni non plus à Winnipeg peut-être ou dans une autre municipalité, uniquement à cause d'un manque d'installations.

M. Wheelock: Je crois que M. Watson a répondu à la question, mais nous avons des problèmes de capacité en ce qui concerne le marché des congrès et des voyages de motivation. Nous aimerions, par exemple, faire beaucoup plus dans le domaine des voyages de motivation en provenance de l'Asie. Toutefois, à partir du moment où il s'agit d'un très grand congrès, les questions d'infrastructure se posent, comme l'a indiqué M. Watson; ainsi, il n'y a qu'un certain nombre de villes canadiennes qui peuvent accueillir une manifestation comme notre propre vitrine d'exposition «Rendez-vous Canada».

D'après la recherche que nous avons effectuée, le tourisme devrait poursuivre sa forte croissance jusqu'en l'an 2010. Certaines villes devront certainement s'efforcer d'avoir les installations voulues si elles veulent rester concurrentielles sur la scène mondiale.

Pour ce qui est du marché des voyages de motivation en provenance de l'Asie, par exemple, nous sommes confrontés au problème du nombre de places disponibles dans les avions. Si 3 000 personnes sont attendues, il n'est pas facile pour quelque société aérienne que ce soit de fournir ce nombre de places. Pour ces genres de marchés, il faut s'organiser longtemps à l'avance. Les planificateurs doivent simplement être au courant à l'avance.

Sur une note positive et pour répondre aux préoccupations du sénateur Callbeck au sujet des petites et moyennes entreprises, nous remarquons une tendance de plus en plus marquée pour les aventures de plein air.

Nous avons utilisé avec succès l'écotourisme et le tourisme d'aventure pour attirer les petits congrès. Nous disons aux participants que nous avons un excellent produit au Canada et qu'ils devraient venir en faire l'expérience. Ainsi, nous avons travaillé avec le programme récréatif national, le programme récréatif américain, pour attirer ces clients. Je pense que nous faisons des progrès à cet égard.

Senator Fairbairn: If you employ the same kind of energy at the CTC that you did at the City of Ottawa, Canadian tourism will really go places.

I have looked at the board and the way in which the membership is distributed. One of the great things about having a Canadian — a national — institution involved in tourism, rather than just at the regional or provincial level, is the opportunity to focus interest on certain parts of Canada that are unique. I am curious about why we do not have a representative whose primary focus is the northern areas of Canada, since it is of great interest to people from many different countries, especially in Europe. We have, under the regional representation, one person for the province of Alberta, the Northwest Territories and the new territory of Nunavut. The Yukon, of course, is “attached” to British Columbia for its representation.

I was in the Northwest Territories last week and it struck me, as always, how exceedingly different the north is. It is just a thought, but maybe there ought to be a special focus on those areas.

Mr. Watson: That is a good observation; you are quite correct. The board composition was designed when the CTC was formed about five years ago, and the proposed legislation keeps the board composition, the categories and so on, in the same ratio. We have representatives from the northern territories on a number of our committees — the research committee, the Canada committee, the industry product development committee, and also the U.S. leisure committee. We believe, notwithstanding the importance of the board and the final decisions that are made there, that the real work of deciding priorities such as where to spend our money in marketing, which is our primary focus, is done at the committee level, and we have representatives on those committees.

I indicated that we have met in the north — we had a meeting of the small/medium enterprise committee in Whitehorse. I will go to the annual general meeting of the Yukon Tourism Association in Whitehorse. We try, in those areas that actually share one board member, to rotate the members. That way, when the term of a representative from P.E.I. and the public sector is over, that arrangement will shift to Nova Scotia. Thus, the Nova Scotia representative will be public and the P.E.I. representative will be private. At some point in the cycle of reappointments, there will be someone from either the Yukon or Nunavut. I cannot tell you when that will happen, because the current appointees will be reappointed on an one-year basis to get us through the Crown Corporation status. The board's nominating committee will then bring forward recommendations on the composition of the board, so that some members will be appointed for three years and others for one year. Thus, we will have a rotation system and new people on the board.

Le sénateur Fairbairn: Si vous déployez le même genre d'énergie à la CCT qu'à la Ville d'Ottawa, le tourisme canadien va certainement faire des étincelles.

J'ai examiné le conseil et la façon dont se répartissent les membres. Ce qu'il y a de très bien au sujet d'une institution canadienne — nationale — qui s'occupe du tourisme, plutôt qu'une institution régionale ou provinciale seulement, c'est qu'il est possible d'attirer l'attention sur certaines régions du Canada qui sont uniques en leur genre. Je me demande pourquoi nous n'avons pas de représentant qui s'intéresse essentiellement aux régions nordiques du Canada, puisque ces régions offrent beaucoup d'attrait aux personnes de l'étranger, notamment aux européens. En ce qui concerne la représentation régionale, nous avons une personne pour la province de l'Alberta, les Territoires du Nord-Ouest et le nouveau territoire du Nunavut. Le Yukon est bien sûr rattaché à la Colombie-Britannique.

Je me trouvais la semaine dernière dans les Territoires du Nord-Ouest et j'ai été frappée, comme toujours, de voir comment le Nord peut être différent d'une région à l'autre. J'ai pensé qu'il faudrait peut-être mettre davantage l'accent sur ces régions.

M. Watson: Votre observation est juste; vous avez tout à fait raison. La composition du conseil d'administration remonte à la création de la CCT il y a environ cinq ans et les mesures législatives proposées ne changent rien à la composition ni aux catégories, et cetera. Nous avons des représentants des territoires du Nord au sein d'un certain nombre de nos comités — le comité de la recherche, le comité du marketing au Canada, le comité de développement des produits et de l'industrie et aussi le comité du marché américain des voyages d'agrément. Nous estimons, malgré l'importance du conseil et des décisions finales qu'il prend, que l'établissement des priorités comme la destination des fonds que nous dépensons en commercialisation, notre secteur d'intervention principal, appartient véritablement aux comités et nous y avons des représentants.

J'ai dit que nous nous sommes réunis dans le Nord — nous avons tenu une réunion du comité des petites et moyennes entreprises à Whitehorse. Je vais assister à l'assemblée générale annuelle de la Yukon Tourism Association à Whitehorse. Nous essayons, dans ces régions qui se partagent en fait un membre au sein du conseil, de faire alterner les membres. Ainsi, lors de l'expiration du mandat d'un représentant de l'Île-du-Prince-Édouard et du secteur public, l'arrangement fait en sorte que nous passerons le flambeau à la Nouvelle-Écosse. Ainsi, le représentant de la Nouvelle-Écosse représentera le secteur public et le représentant de l'Île-du-Prince-Édouard, le secteur privé. À un certain moment au cours du cycle de renouvellement de nomination, il y aura un représentant soit du Yukon soit du Nunavut. Je ne peux vous dire quand cela arrivera parce que les titulaires actuels seront nommés de nouveau pour un mandat d'un an pendant la période de transition qui fera de nous une société d'État. Le comité des candidatures du conseil fera alors des recommandations en ce qui a trait à sa composition de sorte que certains membres seront nommés pour trois ans et d'autres pour un an. Nous aurons ainsi un système de roulement et de nouvelles personnes siégeront au conseil.

That does not answer your question. Perhaps our legal counsel might be able to indicate whether the minister has the authority to expand the composition of the board, or whether there is a legislative requirement.

Senator Fairbairn: That is fine. The point is to determine how the committees operate. There are numerous different things happening in the north — especially within the past year with the development of the diamond mines — a very beautiful area that has so many more opportunities. I understand the constraints under which you are working, but there should be a pitch for people to keep an eye on the territories.

Mr. Watson: I received an e-mail today from our staff that a Martha Stewart program which was filmed entirely in the Yukon will air on October 6, 2000, and will focus on cuisine in the Yukon.

Senator Fairbairn: Every little bit counts.

Mr. Watson: The show is well watched, and they do some creative and imaginative work in the northern territories. For instance, this summer, Whitehorse is receiving three plane loads of tourists each week from Germany. They want to experience the openness and wildlife. A number of Japanese tourists also travel to our north.

Mr. Wheelock: The Japanese have discovered that it is a popular aurora viewing experience and have created tours called "Aurora Viewing." The territories also serve our committees and promote these issues as well. We had an extraordinary meeting of the incentive travel program put together by the Yukon. They took people on an incentive tour in February and did all the winter experience events — camping out on the ice, travel on the rivers, and so on. Wherever there is a market opportunity, we hear about it. If the market is developing one, we will try to work with the product cluster to ensure that it is market ready. We then use various programs to market that in areas where it holds appeal.

Senator Fairbairn: Germany in particular has tremendous interest in aboriginal cultures — north and south.

Mr. Watson: Clause 11 of the bill describes the composition and appointment of board members. It states, in part, that up to seven shall be tourism operators based on geographic considerations, and up to nine shall be private-sector representatives, with no limitations on where those can come from. Those are all under the bill and will be appointees of the Minister of Industry. We can pass the issue that you raised along to the minister or you may wish to pursue that with him.

Senator Callbeck: Apparently Senator Christensen will be featured on the Martha Stewart show.

Cela ne répond pas à votre question. Notre conseiller juridique pourrait peut-être vous dire si le ministre est habilité à augmenter le nombre de membres au sein du conseil ou si cela doit se faire par voie législative.

Le sénateur Fairbairn: Ça va. L'idée c'est de se renseigner au sujet du fonctionnement des comités. Différentes choses se passent dans le Nord — plus particulièrement au cours de la dernière année avec les projets d'exploitation des mines de diamant — une très belle région qui offre tellement de possibilités. Je comprends les contraintes qui vous sont imposées, mais il faudrait dire aux gens de ne pas oublier que les territoires existent.

M. Watson: J'ai reçu aujourd'hui d'un employé un courriel où il est dit qu'une émission de Martha Stewart, filmée entièrement au Yukon, sera diffusée le 6 octobre 2000 et portera sur la cuisine au Yukon.

Le sénateur Fairbairn: La moindre petite chose compte.

M. Watson: L'émission est assez populaire et dans les Territoires du Nord-Ouest il se fait des choses créatrices et audacieuses. Par exemple, cet été, Whitehorse accueille toutes les semaines trois avions remplis de touristes allemands. Ces gens veulent faire l'expérience des grands espaces et admirer la faune et la flore. Un certain nombre de touristes japonais voyagent aussi dans le nord du Canada.

M. Wheelock: Les Japonais ont découvert que c'est un endroit populaire pour observer les aurores polaires et ont organisé des visites qu'ils appellent «Observation d'aurores polaires». Les territoires sont utiles à nos comités et font la promotion également de ces produits. Nous avons tenu une réunion extraordinaire du comité des voyages de motivation à l'initiative du Yukon. En février, des gens ont participé à un voyage de motivation et ont participé à toute la panoplie d'activités hivernales — camping sur la glace, navigation sur les rivières, et cetera. Dès qu'il y a un débouché commercial, nous en entendons parler. Si le marché met au point un produit, nous allons essayer de travailler avec la grappe de produits pour faire en sorte qu'elle soit immédiatement commercialisable. Nous utilisons ensuite divers programmes pour en faire la commercialisation dans les régions que le produit intéresse.

Le sénateur Fairbairn: L'Allemagne plus particulièrement s'intéresse énormément aux cultures autochtones — du nord et du sud.

M. Watson: À l'article 11 du projet de loi, il est question de la composition et de la nomination des membres du conseil. Il y est dit en partie que sept au plus sont des exploitants d'entreprises touristiques dont le nombre est réparti entre les provinces et les territoires et neuf au plus sont des représentants du secteur privé, aucune restriction quant à leur provenance n'étant imposée. La loi s'applique à tous et ils sont nommés par le ministre de l'Industrie. Nous pouvons transmettre au ministre la question que vous avez soulevée ou vous voudrez peut-être en discuter avec lui.

Le sénateur Callbeck: À ce qu'il paraît, le sénateur Christensen serait mise en vedette dans l'émission de Martha Stewart.

Senator Kennedy: Mr. Watson, you have a wonderful, challenging job ahead of you.

The commission may enter into an agreement with the government of any province or territory to carry out its objectives. What has your experience been in the past? Has the commission done this before and to what extent has that become a part of your work?

Mr. Watson: We have a very good working relationship with all of the provinces, without exception. The farther away from Canada you go, the more difficult it is to sell a province or a city, so you sell the country instead. We have very positive relationships with all the provinces in joint marketing activities. Granted, I have only been here about four weeks and have attended one executive committee board meeting, where we met with the deputy ministers from different provinces. It is a very cordial and positive relationship because we are working toward the same goal — we want to see more tourists come to Canada and more Canadians spend their money in this country. Subsequently, our board must decide whether to enter into multi-year agreements or continue on a bilateral basis, as we have been doing to date.

That is a somewhat divisive issue, because the strength of the organization to date has been that all of the marketing plans have been driven by the private sector committee, which brings forward recommendations on how to spend the money to the board, and the board makes the final decision. I think Mr. Wheelock has a comment with respect to some statistics vis-à-vis the issue you raised.

Mr. Wheelock: It is an important issue, but in fact we are making great strides even without the formal memorandum of understanding. In 1997-98, the provinces contributed about \$7 million to joint marketing programs with the CTC. In 1998, that had nearly doubled to \$13 million. In 1999 and the current year, we are up to about \$27 million. Part of that is driven by the fact that the provinces have significantly increased their own marketing budgets, so they are able to do more. However, they realize that the tripartite arrangement between the CTC, their own provincial marketing organizations — whether line departments of the government or special operating agencies — and the industry, can create a needed critical mass to market the country effectively. The Australian government alone, for example, has committed about the equivalent of our total marketing dollars. The competition is huge, as is the need to amass those resources. However, with or without the memorandum of understanding, we are getting significant contributions from the provinces in all our marketing programs.

Senator Kennedy: Mr. Watson, you talked about the new structure that allows you to open bank accounts in other countries where you will be functioning. Do you know, at this stage, what kind of budget you will have for that? It only makes sense to go where the people are to invite them. How will you balance that

Le sénateur Kennedy: Monsieur Watson, un merveilleux défi vous attend.

La commission peut conclure une entente avec le gouvernement de n'importe quelle province ou territoire pour atteindre ses objectifs. Quelle a été votre expérience par le passé? Est-ce que c'est une première pour la commission ou dans quelle mesure cela fait-il maintenant partie de votre travail?

M. Watson: La dynamique de notre relation avec toutes les provinces est très bonne, sans exception. Plus vous vous éloignez du Canada, plus il est difficile de vendre une province ou une ville de sorte que nous vendons plutôt le pays. Nous avons des relations très positives avec toutes les provinces en ce qui a trait à la commercialisation des produits. Je vous l'accorde, je ne suis ici que depuis environ quatre semaines et je n'ai assisté qu'à une réunion du comité de direction du conseil d'administration où nous rencontrons les sous-ministres de différentes provinces. Les relations sont très cordiales et très positives parce que nous visons le même objectif — nous voulons attirer davantage de touristes et encourager les Canadiens à dépenser davantage dans leur pays. Notre conseil d'administration doit donc décider si nous devons conclure des ententes pluriannuelles ou continuer sur une base bilatérale, comme nous l'avons fait jusqu'à maintenant.

C'est une question qui est en quelque sorte une source de division étant donné que l'atout de l'organisme jusqu'à maintenant a été de confier tous les plans de commercialisation au comité du secteur privé, qui fait des recommandations au conseil sur la façon de dépenser l'argent. Le conseil prend la décision finale. Je pense que M. Wheelock a quelque chose à dire en ce qui concerne certaines statistiques relatives à la question que vous avez soulevée.

M. Wheelock: C'est une question importante, mais en fait nous faisons de grands progrès même sans le protocole d'entente officiel. En 1997-1998, les provinces ont contribué à hauteur de 7 millions de dollars au programme conjoint de commercialisation avec la CCT. En 1998, elles ont presque doublé leur participation qui a atteint 13 millions de dollars. En 1999 et pour l'année en cours, nous atteignons presque 27 millions de dollars. Cela est en partie attribuable au fait que les provinces ont augmenté sensiblement leur propre budget de commercialisation et qu'elles peuvent contribuer davantage. Cependant, elles se rendent compte que l'accord tripartite entre le CCT, leurs propres organismes de commercialisations provinciaux — qu'il s'agisse de services opérationnels du gouvernement ou d'organismes de services spéciaux — et l'industrie, peut créer la masse critique nécessaire pour vendre le pays efficacement. Par exemple, le gouvernement australien a lui seul engagé à peu près l'équivalent des montants globaux que nous avons investis dans la commercialisation. La concurrence est forte tout comme le besoin est énorme d'amasser ces ressources. Cependant, avec ou sans protocole d'entente, les provinces collaborent grandement à tous nos programmes de commercialisation.

Le sénateur Kennedy: Monsieur Watson, vous avez parlé de la nouvelle structure qui vous permet d'ouvrir des comptes de banque dans d'autres pays où vous exercerez vos activités. Connaissiez-vous, à l'heure qu'il est, le budget dont vous disposerez pour cela? La seule logique, selon moi, est de se rendre

kind of offshore investment in time and energy in getting our message out?

Mr. Watson: That is determined by our research on what our priority markets are. We can provide members of the committee with a breakdown of how much we spent on various different areas. For example, in Asia Pacific this year, our core budget is \$9 million, and \$9 million partnered with the private sector, for a total of \$18 million. In Europe, the core budget is \$10 million, and \$19.7 million in partnered. In U.S. leisure, the core budget is \$18 million, and \$31 million in partnered, and so on.

Therefore, we believe that we have a formula that works. It certainly has been a positive experience, given the number of tourists who have visited the country — individuals who have come to experience Canada as a tourism destination. We are in constant contact with the provinces to look at their priorities. For instance, the priority for the Atlantic provinces is the New England states because of the proximity to their border.

Senator Kennedy: The bill states that the board will meet twice each year. Do you feel that that is adequate?

Mr. Watson: I am not in a position to answer that because I have yet to go to my first board meeting. The executive committee has the power and authority of the board, and it meets more frequently. Ultimately, the board will decide whether we should meet more often. The target that the chairman of the board has set out is to try to meet four times each year.

Senator Kennedy: That sounds more reasonable.

Mr. Watson: Ms Péan has provided me with a draft of the agenda, and it is a long, substantive meeting. That is because our last meeting was several months ago in Calgary. Greater frequency, obviously, would allow the board to make decisions more frequently. In the interim, the executive committee of the board, under our rules and regulations, has the authority of the board.

Senator Kennedy: I wish you well.

The Chairman: Mr. Watson, may I say, in wrapping up, that your grasp of the business is awesome. This bodes well for the department and for the future of the Crown corporation.

We will proceed with clause by clause. Can I have a motion?

Senator Banks: I so move.

The Chairman: Can I have a motion to dispense with clause by clause?

Senator Carstairs: I so move.

là où les gens sont pour les inviter. Comment allez-vous mettre en balance ce placement à l'étranger en temps et en efforts pour faire passer votre message?

M. Watson: C'est la recherche effectuée par la Commission qui sert à établir nos marchés prioritaires. Nous pouvons fournir aux membres du comité une ventilation de nos dépenses dans les différents secteurs. Par exemple, en Asie-Pacifique cette année, notre budget de base est de 9 millions de dollars et de 9 millions en partenariat avec l'entreprise privée, pour un total de 18 millions. En Europe, nous parlons de 10 millions pour ce qui est du budget de base et de 19,7 millions en partenariat. Dans les voyages d'agrément américains, le budget de base est de 18 millions et de 31 millions en partenariat, et cetera.

Par conséquent, nous croyons disposer d'une formule efficace. L'expérience a certes été positive étant donné le nombre de touristes qui ont visité le pays — des personnes qui ont choisi le Canada comme destination touristique. Nous sommes en contact constant avec les provinces pour examiner leurs priorités. Par exemple, la priorité des provinces de l'Atlantique, ce sont les États de la Nouvelle-Angleterre en raison de la proximité de leur frontière.

Le sénateur Kennedy: Le projet de loi dispose que le conseil d'administration se réunira deux fois par année. Est-ce suffisant d'après vous?

M. Watson: Je ne suis pas en mesure de vous répondre étant donné que je n'ai pas encore assisté à ma première réunion du conseil. Le pouvoir et l'autorité du conseil sont assumés par le comité exécutif qui se réunit plus fréquemment. C'est le conseil d'administration qui décidera au bout du compte s'il est souhaitable que nous réunissions plus souvent. Le président du conseil d'administration s'est fixé comme objectif d'essayer de tenir des réunions quatre fois l'an.

Le sénateur Kennedy: Cela me semble plus raisonnable.

M. Watson: D'après l'ébauche d'ordre du jour que m'a remis Mme Péan la réunion sera longue et chargée. Cela est dû au fait que notre dernière réunion remonte à plusieurs mois, à Calgary. Il est évident que si le conseil multipliait ses réunions, il pourrait prendre des décisions plus souvent. En attendant, le comité exécutif du conseil, d'après nos règles et règlements, assume le pouvoir du conseil.

Le sénateur Kennedy: Je vous souhaite bonne chance.

Le président: Monsieur Watson, puis-je vous dire, pour terminer, que votre maîtrise du sujet est impressionnante. Cela augure bien pour l'avenir de la Société d'État.

Nous allons procéder à l'étude article par article. Quelqu'un peut-il proposer une motion?

Le sénateur Banks: Je le propose.

Le président: Quelqu'un peut-il proposer que nous passions outre à cette étude?

Le sénateur Carstairs: Je le propose.

The Chairman: Can I have a motion to report the bill back to the Senate without amendment?

Senator LeBreton: I so move.

The committee adjourned.

Le président: Quelqu'un peut-il proposer que je fasse rapport du projet de loi au Sénat sans amendement?

Le sénateur LeBreton: Je le propose.

La séance est levée.



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WITNESSES—TÉMOINS

From the Canadian Tourism Commission:

Jim Watson, President;
Roger Wheelock, Vice-President, Marketing;
Chantal Péan, Director, Industry and Corporate Affairs.

From Industry Canada:

Irving Miller, Senior Counsel, Legal Services.

De la Commission canadienne du tourisme:

Jim Watson, président;
Roger Wheelock, vice-président, Marketing;
Chantal Péan, directrice, Affaires internes et de l'industrie.

D'Industrie Canada:

Irving Miller, avocat-conseil, Services juridiques.



Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

*Proceedings of the Standing
Senate Committee on*

*Délibérations du comité
sénatorial permanent des*

Social Affairs, Science and Technology

Affaires sociales, des sciences et de la technologie

Chairman:
The Honourable MICHAEL KIRBY

Président:
L'honorable MICHAEL KIRBY

Thursday, September 21, 2000

Le jeudi 21 septembre 2000

Issue No. 20

Fascicule n° 20

Thirteenth meeting on:
The state of the health care system in Canada

Treizième réunion concernant:
L'état du système de santé au Canada

and

et

First meeting on:
The health care provided to veterans of war and
of peacekeeping missions.

Première réunion concernant:
Les soins de santé offerts aux anciens combattants qui
ont servi au cours de guerres ou dans le cadre
d'opérations de maintien de la paix

WITNESS:
(See back cover)

TÉMOIN:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Fairbairn, P.C.
Beaudoin	Kennedy
* Boudreau, P.C. (or Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Robertson
Cook	

* *Ex Officio Members*

(Quorum 4)

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Banks	Fairbairn, c.p.
Beaudoin	Kennedy
* Boudreau, c.p. (ou Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Robertson
Cook	

* *Membres d'office*

(Quorum 4)

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Wednesday, June 28, 2000:

The Honourable Senator DeWare for the Honourable Senator Meighen moved, seconded by the Honourable Senator Gustafson:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the health care provided to veterans of war and of peacekeeping missions; the implementation of the recommendations made in its previous reports on such matters; and the terms of service, post-discharge benefits and health care of members of the regular and reserve forces as well as members of the RCMP and of civilians who have served in close support of uniformed peacekeepers;

That the Committee report no later than June 30, 2001; and

That the Committee be permitted, notwithstanding usual practices, to deposit its report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

The question being put on the motion, it was adopted.

ORDRE DE RENVOI

Extrait des *Journaux du Sénat* du mercredi 28 juin 2000:

L'honorable sénateur DeWare, au nom de l'honorable sénateur Meighen, propose, appuyé par l'honorable sénateur Gustafson,

Que le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie soit autorisé à examiner les soins de santé offerts aux anciens combattants qui ont servi au cours de guerres ou dans le cadre d'opérations de maintien de la paix; les suites données aux recommandations faites dans ses rapports précédents sur ces questions; et les conditions afférentes aux services, prestations et soins de santé offerts, après leur libération, aux membres de l'armée permanente ou de la réserve, ainsi qu'aux membres de la GRC et aux civils ayant servi auprès de casques bleus en uniforme dans des fonctions d'appui rapproché, et à faire un rapport sur ces questions.

Que le Comité fasse rapport au plus tard le 30 juin 2001; et

Que le Comité soit autorisé, nonobstant les pratiques habituelles, à déposer son rapport auprès du Greffier du Sénat si le Sénat ne siège pas, et que ledit rapport soit réputé avoir été déposé au Sénat.

La motion, mise aux voix, est adoptée.

Le Greffier du Sénat,

Paul C. Bélisle

Clerk of the Senate

MINUTES OF PROCEEDINGS

OTTAWA, Thursday, September 21, 2000
(28)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 11:04 a.m., the Deputy Chair, the Honourable Marjory LeBreton, presiding.

Members of the committee present: The Honourable Senators Banks, Cohen, Fairbairn, Kennedy, Keon, Kirby, LeBreton and Robertson (8).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Julie Mackenzie.

Also in attendance: The official reporters of the Senate.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see proceedings of the committee, Issue No. 8.*)

WITNESS:

As an individual:

Graham Scott, Former Deputy Minister of Health, Province of Ontario.

The Deputy Chair made a statement.

Mr. Scott made a statement and answered questions.

At 11:15 a.m., Senator Kirby took the Chair.

Pursuant to the Order of Reference adopted by the Senate on Wednesday, June 28, 2000, the committee began its consideration of the state of the health care provided to veterans of war and of peacekeeping missions.

The Chair made a statement.

It was moved by Senator Banks — That the Subcommittee on Veterans Affairs be authorized to examine and report on the health care provided to veterans of war and of peacekeeping missions; the implementation of the recommendations made in its previous reports on such matters; and the terms of service, post-discharge benefits and health care of members of the regular and reserve forces as well as members of the RCMP and of civilians who have served in close support of uniformed peacekeepers.

The question being put on the motion, it was adopted.

It was moved by Senator Robertson — That the Chairman seek the following order of reference from the Senate:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the developments since Royal Assent was given to Bill C-6, An Act to support and promote electronic commerce by protecting personal information that is

PROCÈS-VERBAL

OTTAWA, le jeudi 21 septembre 2000
(28)

[Traduction]

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 11 h 04, dans la pièce 705 de l'édifice Victoria, sous la vice-présidence de l'honorable Marjory LeBreton (*vice-présidente*).

Membres du comité présents: Les honorables sénateurs Banks, Cohen, Fairbairn, Kennedy, Keon, Kirby, LeBreton et Robertson (8).

Également présentes: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement: Odette Madore et Julie Mackenzie.

Aussi présents: Les sténographes officiels du Sénat.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale sur l'état du système de santé au Canada. (*L'ordre de renvoi figure dans le fascicule n° 8 du comité.*)

TÉMOIN:

À titre personnel:

Graham Scott, ancien sous-ministre de la Santé, province de l'Ontario.

La vice-présidente fait une déclaration.

M. Scott fait une déclaration et répond aux questions.

À 11 h 15, le sénateur Kirby occupe le fauteuil.

Conformément à l'ordre de renvoi adopté par le Sénat le mercredi 28 juin 2000, le comité entreprend son examen des soins de santé offerts aux anciens combattants qui ont servi au cours de guerres et dans le cadre d'opérations de maintien de la paix.

Le président fait une déclaration.

Le sénateur Banks propose — Que le sous-comité des affaires des anciens combattants soit autorisé à examiner les soins de santé offerts aux anciens combattants qui ont servi au cours de guerres ou dans le cadre d'opérations de maintien de la paix; les suites données aux recommandations faites dans ses rapports précédents sur ces questions; et les conditions afférentes aux services, prestations et soins de santé offerts, après leur libération, aux membres de l'armée permanente ou de la réserve, ainsi qu'aux membres de la GRC et aux civils ayant servi auprès de casques bleus en uniforme dans des fonctions d'appui rapproché, et à faire un rapport sur ces questions.

La question, mise aux voix est adoptée.

Le sénateur Robertson propose — Que le président demande au Sénat de confier l'ordre de renvoi suivant au comité:

Que le comité sénatorial permanent des affaires sociales, des sciences et de la technologie soit autorisé à examiner, pour en faire rapport, sur les faits nouveaux survenus depuis la sanction royale du projet de loi C-6, Loi visant à faciliter et à promouvoir le commerce électronique en protégeant

collected, used or disclosed in certain circumstances, by providing for the use of electronic means to communicate or record information or transactions and by amending the Canada Evidence Act, the Statutory Instruments Act and the Statute Revision Act; and

That the committee table its final report no later than December 31, 2000.

After debate, the question being put on the motion, it was adopted.

At 12:29 p.m., the committee adjourned to the call of the Chair.

ATTEST:

les renseignements personnels recueillis, utilisés ou communiqués dans certaines circonstances, en prévoyant l'utilisation de moyens électroniques pour communiquer ou enregistrer de l'information et des transactions et en modifiant la Loi sur la preuve au Canada, la Loi sur les textes réglementaires et la Loi sur la révision des lois; et

Que le comité dépose son rapport au plus tard le 31 décembre 2000.

Après discussion, la question, mise aux voix, est adoptée.

À 12 h 29, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

EVIDENCE

OTTAWA, Thursday, September 21, 2000

The Standing Senate Committee on Social Affairs, Science and Technology met this day at 11:04 a.m. to examine the state of the health care system in Canada.

Senator Marjory LeBreton (*Deputy Chairman*) in the Chair.

[English]

The Deputy Chairman: Honourable senators, our witness this morning is Mr. Graham Scott, who is known to many of us in many capacities, myself included. I once worked for him in the office of the Honourable Robert Stanfield. Mr. Scott is here today to speak to us on our study of the health care system in Canada. He is speaking to us from his experience as a former provincial deputy minister of health.

Mr. Scott, please proceed.

Mr. Graham Scott, Former Deputy Minister of Health, Province of Ontario: Thank you, honourable senators. I am honoured to have the opportunity to share with you some of my thoughts with regard to the status of health care in Canada. I have had the privilege of reading some of the testimony to your committee by some distinguished guests and I wish to endorse every single word in the opening statement of Mr. Tom Kent. I thought it was thoughtful and straightforward. The subject matter that he covered reflected most of my views.

Obviously, a great deal has occurred since I submitted my presentation in June. That said, I do not think most of the presentation has been meaningfully altered by those events. My experience in both the federal and provincial jurisdictions tells me that both jurisdictions definitely have a legitimate role to play in health care policy, and it is essential that they work effectively together.

I do not wish to address the political wins and losses arising from the federal-provincial agreement this month, but it is worthwhile to consider what impact that agreement has on the road to finding a solution to the principal problems confronting health care in Canada. The agreement will provide the provinces with much-needed cash to address a build-up of problems over the last half of the previous decade. My fear, however, is that the money will flow to immediate political pressure points in the system and not address the longer term problems required to fully rebuild public confidence and ensure that the system is focused on its goals. To better understand that, one need only look at the media today and note that substantial pressure has already arisen from providers, demanding that they get immediate attention as a result of this transfer of cash.

The providers themselves are quite capable of swallowing up all that money overnight if caution is not utilized. In my most optimistic moments, my scenario is that the provinces will at least use some of the money to grease the skids on reforms to improve the system in areas such as technology and alternate payment plans. I do not believe, however, the agreement will do anything

TÉMOIGNAGES

OTTAWA, le jeudi 21 septembre 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 11 h 04 afin d'examiner l'état du système de santé au Canada.

Le sénateur Marjory LeBreton (*vice-présidente*) occupe le fauteuil.

[Traduction]

La vice-présidente: Honorables sénateurs, notre témoin ce matin est M. Graham Scott, que bon nombre d'entre nous, dont moi-même, connaissons à divers titres. J'ai travaillé sous sa direction au bureau de l'honorable Robert Stanfield. M. Scott est ici aujourd'hui pour ajouter des éléments à notre étude du système de santé au Canada. Il témoigne, à cette occasion, à titre d'ancien sous-ministre provincial de la Santé.

Monsieur Scott, je vous laisse la parole.

M. Graham Scott, ancien sous-ministre de la Santé, Ontario: Merci, honorables sénateurs. Je suis heureux d'avoir cette occasion de vous faire part de certaines de mes opinions au sujet de l'état du système de santé du Canada. J'ai eu le privilège de lire certains des témoignages d'invités distingués de votre comité et j'aimerais signaler mon appui à l'ensemble de la déclaration préliminaire de M. Tom Kent. J'ai trouvé cette déclaration réfléchie et directe. Les idées qu'il exprimait reflétaient en grande partie mes points de vue.

De toute évidence, beaucoup de choses sont survenues depuis l'exposé que je vous ai fait en juin. Ceci dit, je ne crois pas que ces événements aient modifié grand-chose à la teneur de cet exposé. D'après l'expérience que j'ai de l'administration fédérale et provinciale, les deux compétences ont décidément un rôle légitime à jouer dans la politique des soins de santé, et il est essentiel qu'elles collaborent efficacement.

Je ne tiens pas à parler des bons et des mauvais côtés de l'entente conclue entre les gouvernements fédéral et provinciaux ce mois-ci, mais il serait bon de réfléchir aux effets que pourrait avoir cette entente sur la recherche d'une solution aux plus grands problèmes que connaît le système de santé au Canada. L'entente permettra aux provinces de recevoir des fonds dont elles ont grand besoin pour s'occuper des problèmes qui se sont accumulés depuis le milieu des années 90. Ma crainte, cependant, est que l'argent abondera vers les points de pressions politiques immédiates dans le système, sans que rien ne soit fait relativement aux problèmes à plus long terme en vue de rebâtir la confiance du public et de faire en sorte à ce que le système reste axé sur ses objectifs. Pour mieux comprendre ceci, il suffit de regarder les médias d'aujourd'hui pour voir que des pressions importantes ont déjà été exercées par des fournisseurs de services, qui exigent de recevoir une attention immédiate à la suite de ce transfert de fonds.

Les fournisseurs eux-mêmes sont tout à fait capables d'engloutir tout cet argent en un rien de temps si les précautions appropriées ne sont pas prises. Dans mes moments les plus optimistes, je me dis que les provinces prendront au moins une partie de cet argent pour faire accélérer des réformes visant à améliorer le système dans des domaines comme la technologie et

to improve the state of federal-provincial relations except to introduce a quieter period for a short time. I believe the only answer is to tie the federal government and the provinces together in their commitment so that they share a common interest in the system's success and can agree to advance some reforms together. If the federal commitment was tied to system costs and performance as suggested by Mr. Kent, then it is possible that they would have enough in common to work together on reforms. Until there is a mutual incentive to solve problems, the most difficult ones will not be addressed.

The most crucial issue at the moment in the health care system, of which the public is not fully aware, is the shortage of human resources and professional human resources within the health care system. All the money in the world cannot produce doctors in one, two or three years and cannot produce more nurses in one, two or three years and cannot produce radiation technology to deal with the problem. I predict that the provinces will find themselves in a great deal of difficulty, money notwithstanding, in very short order.

Money will support current systems, but one must bear in mind that many of the current systems do not work well. In reinforcing, for example, some of the existing professional payment systems, they may stifle reform.

The challenge that lies ahead is to avoid the apparently simple solutions that some propose, which would make matters considerably worse. I wish you well in developing a report that will address the debate and, hopefully, bring it toward a constructive solution.

Senator Robertson: Thank you for coming here this morning, Mr. Scott. I have been looking forward to your presentation. I read over your printed comments a few times. In your overview of the last agreement between the federal and provincial governments, you suggested that money will support the current system. I suggest to you that this is not correct. It is the small provinces that really get hit. In my province, the last financial agreement gives us funds for two weeks of health care and that is all. The rest of the time it is a downhill run. We are nervous about that. The other small provinces are in the same position. We do not have the money to change the system. What comes first? We must change the system, but we must have money to keep operating and money to change the system. It will be a difficult time, in particular, for the smaller provinces. It will be a disaster for the small provinces.

I wrote a few notes during your presentation. I agree with you about the family physicians. On page 7 you speak to the issue of family physicians moving to office practice and the momentum to move fees away from hospital practice to office practices. You note how this growing tendency has negatively influenced hospital operations, both urban and rural. You argue that this tendency has further threatened the quality of primary care medicine by

les autres modes de paiement. Je ne crois pas, cependant, que l'entente puisse faire quoi que ce soit pour améliorer l'état des relations fédérales-provinciales, à part la courte période d'accalmie qu'elle suscitera. Je crois que la seule solution est de lier les gouvernements fédéral et provinciaux dans leur engagement, pour qu'ils aient un intérêt commun envers le succès du système et qu'ils puissent convenir de veiller ensemble au progrès de certaines réformes. Si l'engagement fédéral était lié aux coûts et au rendement du système, comme le suggère M. Kent, il se peut alors qu'ils aient assez en commun pour collaborer à la réalisation de réformes. Tant qu'il n'y aura pas d'incitatifs mutuels pour la résolution des problèmes, le plus difficile ne sera pas abordé.

Le problème le plus important du système de santé, celui dont le public n'est pas vraiment conscient, est le manque de ressources humaines et professionnelles. Tout l'argent du globe ne pourra pas produire des médecins en un, deux ou trois ans, ne fera pas apparaître plus d'infirmières en un, deux ou trois ans, et ne créera pas la technologie de radiothérapie nécessaire à la résolution du problème. Je prévois que les provinces se trouveront en très grande difficulté, qu'elles aient de l'argent ou non, à très court terme.

L'argent soutiendra les systèmes actuels, mais il ne faut pas oublier que bon nombre d'entre eux ne fonctionnent pas bien. Le renforcement, par exemple, de certains des systèmes en rémunération des professionnels pourrait faire entrave à la réforme.

Le défi qui se pose est d'éviter les solutions apparemment simples que certains proposent, qui pourraient en fait beaucoup envenimer la situation. Je vous souhaite bonne chance dans l'élaboration d'un rapport qui viendra à bout du débat et, nous l'espérons, mènera à une solution constructive.

Le sénateur Robertson: Je vous remercie d'être ici ce matin, monsieur Scott. J'étais impatiente de vous entendre. J'ai lu et relu les commentaires que vous avez présentés sur papier. Dans l'examen que vous avez fait de la dernière entente conclue entre les gouvernements fédéral et provinciaux, vous laissez entendre que l'argent soutiendra le système actuel. À mon avis, vous vous trompez. Ce sont les petites provinces qui sont vraiment touchées. Dans ma province, le dernier accord financier nous octroie des fonds pour deux semaines de soins de santé, c'est tout. Le reste du temps, c'est la descente. Cela nous inquiète. Les autres petites provinces sont dans la même position. Nous n'avons pas l'argent nécessaire pour changer le système. À quoi donner la priorité? Il faut changer le système, mais il faut de l'argent pour continuer de fonctionner, et de l'argent pour changer le système. Les temps difficiles arrivent, en particulier pour les provinces de moindre envergure. Ce sera un désastre pour les petites provinces.

J'ai pris quelques notes pendant votre exposé. Je suis d'accord avec vous au sujet des médecins de famille. À la page 7 de votre document, vous parlez du problème du plus grand nombre de médecins de famille qui passent à la pratique en cabinet. Vous faites remarquer que cette tendance croissante a eu un effet négatif sur le travail en milieu hospitalier, à la fois dans les villes et dans les campagnes. Vous dites que cette tendance croissante

separating many family physicians from the learning environment found in the hospital setting.

One could not disagree with what you say. However, I should like to know your recommendation to solve that problem given a large body of thought that believes there should only be rooms in the hospital for those who are extremely ill and whose lives are in danger of an invasive process. These people believe that everything else should be done in the community or in the workplace, which keeps the family practitioner out there.

Do you have a solution to that problem that we all recognize? The reality is that our hospitals, as we know them, will increasingly have room for specialists.

Mr. Scott: You could look at the problem on two levels. In the urban centres with the teaching hospitals, and particularly those that do more complex secondary and tertiary care, it is quite true that most of the physicians working permanently in the hospital will be specialists. I do not think that this would prevent affiliation arrangements between family doctors and the hospital. Some of the teaching hospitals and larger community hospitals in the cities do have a family practice unit, and sometimes quite a large family practice unit, that can coordinate with a speciality care service that is provided.

The current problem is not just a question of privileges in the hospital. I do not think that full privileges are needed. There needs to be a relationship, a confidence, that exists between the practitioners in the field and the hospital. Some relationship is necessary. I think that is one way.

The situation is most serious in the smaller communities, those with a population of 10,000 to 15,000. In the urban growth areas like southern Ontario, a number of doctors will no longer have anything to do with the hospital, period. They do not maintain a relationship or a regular knowledge of what is happening at the hospital because they believe that the time they spend at the hospital costs them money. In those circumstances, hospitals are becoming more and more understaffed and the family doctors who are voluntarily working in those hospitals are coming under more and more pressure. Therefore, service is getting worse.

In under-serviced areas, the situation is exacerbated even further. With the doctor shortage, perhaps one in four or one in five doctors who are now standing on call are questioning why they need to stand on call anymore. They believe that they could go into practice in another community, not stand on call, and roll things through on a fee-for-service basis. That threatens the entire system.

I will make a final point, which is one that bothers me and many miss, regarding family doctors practising on their own without consulting with their colleagues in a hospital setting. In the northern under-serviced areas, doctors do consult because they must consult each other due to the nature of the problems that they face. However, it is worse in the cities because doctors are

compromet la qualité des soins primaires, en isolant de nombreux médecins de famille du milieu d'apprentissage que constitue l'hôpital.

On ne pourrait pas vous contredire là-dessus. Cependant, j'aimerais savoir ce que vous recommandez pour résoudre ce problème, étant donné qu'il y a pas mal de gens qui trouvent qu'il ne devrait y avoir de chambres dans les hôpitaux que pour ceux qui sont très malades et dont la vie est en danger en raison d'une procédure effractive. Ces gens-là trouvent que tout le reste des soins doit se donner dans la communauté ou au travail. C'est donc aussi là que doivent être les médecins de famille.

Avez-vous une solution à proposer à ce problème que nous reconnaissons tous? La réalité c'est que nos hôpitaux, tels que nous les connaissons, n'auront de plus en plus de place que pour les spécialistes.

M. Scott: On peut envisager ce problème à deux niveaux. Dans les centres urbains qui ont des hôpitaux d'enseignement, et particulièrement ceux qui offrent des soins secondaires et tertiaires plus complexes, il est bien vrai que la plupart des médecins qui y auront un poste permanent seront des spécialistes. Je ne crois pas que cela devrait empêcher les médecins de famille et les hôpitaux de conclure des contrats d'affiliation. Certains hôpitaux d'enseignement et les plus grands hôpitaux communautaires, dans les villes, sont dotés d'une unité de médecine familiale, qui est parfois assez importante et qui peut coordonner ses activités avec celle d'un service de soins spécialisés qui est fourni.

Le problème actuel n'est pas seulement une question de privilèges dans l'hôpital. Je ne dis pas qu'il faille accorder tous les privilèges. Il faut qu'il y ait une relation, une confiance, entre les praticiens du domaine et l'hôpital. Ces rapports sont indispensables. Pour moi, c'est l'une des solutions.

La situation est bien plus grave dans les plus petites communautés, celles de 10 000 ou 15 000 habitants. Dans les zones de croissance urbaine comme le sud de l'Ontario, il y a des médecins qui ne veulent plus rien avoir à faire avec les hôpitaux, un point c'est tout. Ils n'entretiennent pas de rapport avec l'hôpital, ni ne se tiennent au courant de ce qui s'y passe parce qu'ils estiment que le temps passé à l'hôpital leur coûte de l'argent. C'est là que le manque de personnel des hôpitaux se fait de plus en plus criant et que les médecins de famille qui travaillent volontairement dans ces hôpitaux subissent des pressions de plus en plus grandes. Et là, la qualité du service en souffre.

Dans les secteurs sous-équipés, la situation est encore pire. Avec le manque de médecins, peut-être un sur quatre ou cinq médecins qui travaillent sur appel remet en question son obligation de le faire. Ils se disent qu'ils pourraient ouvrir un cabinet dans une autre communauté, ne pas être sur appel, et fonctionner selon formule de rémunération à l'acte. Cela met en péril le système tout entier.

Je vais présenter un dernier élément qui me préoccupe et auquel beaucoup de gens ne pensent pas, au sujet des médecins de famille qui travaillent seuls sans consulter leurs collègues du milieu hospitalier. Dans les régions du Nord qui manquent de services, les médecins se consultent effectivement, parce que la nature des problèmes qu'ils affrontent les oblige à se consulter

becoming more and more the victims of scripts from pharmaceutical companies and others. These companies are telling physicians how to practise medicine because they are not interacting with their colleagues. If you do not interact with your colleagues, you cannot maintain your skills over a period of time.

Senator Robertson: I appreciate that the pressure is always financial and that the family practitioner is encouraged to keep his or her patients who require family medicine. I do not know the current costs; years ago we had a firm figure. It cost seven and one-half times more for the patient to go to the outpatient section of a hospital rather than the family doctor's office. The difference in cost causes concern.

I agree that there must be communication. There must be an opportunity for absorbing knowledge. However, I am not sure that most hospitals, even in the small communities, will be there much longer. Their services really can be done elsewhere in the community. Treating people in the hospital is the most expensive approach. People can be treated other than through the hospital.

People do not need to go to hospital to receive treatment. Most of the family physicians and many of the specialists are of this opinion. Patients can be treated outside of the hospital. We want to end this "hotel hospital" impression.

In Atlantic Canada, you could walk through a hospital on any day and see that 30 per cent or 40 per cent of the patients occupying beds could be treated elsewhere. We must change that.

This begs the following question: What should the doctors do? How do they join with their specialist colleagues to maintain their motivation to improve and not run their practice based on the information that the drug peddlers leave at the door?

Mr. Scott: I would add that there are different ways of doing this. One way is for the hospital to establish a group practice in conjunction with the hospital operations. Many of the "non-emergency" emergency visitors could be streamed through that system.

Another way is to have good community practices, with good affiliation arrangements with the hospital. That approach would cover the educational side as well. However, that requires an alternate funding program. When that type of arrangement is in place, there is a notable difference.

From my experience in northern and rural Ontario, I would rather attend one of their overly stressed family doctors than a doctor in Scarborough or Mississauga in a sole practice. The doctors in the remote area work well together. They realize that their patients do not want to travel 250 miles because the local doctor may have never seen a certain mould before. Therefore, the rural doctors go to an extra level to learn things. We do not do enough as a system to support physicians, particularly from academic health science centres.

entre eux. Par contre, la situation est pire dans les villes parce que les médecins sont de plus en plus les victimes de scénarios montés par des compagnies pharmaceutiques et autres. Ce sont ces compagnies qui dictent aux médecins comment pratiquer la médecine, parce qu'ils n'entretiennent pas de rapports avec leurs collègues. Sans ces échanges avec les collègues, il est impossible de maintenir ses compétences bien longtemps.

Le sénateur Robertson: Je comprends que les pressions sont toujours d'ordre financier et que les médecins de famille sont encouragés à garder leurs patients qui ont besoin des soins d'un médecin de famille. Je ne sais rien des coûts actuels; il y a plusieurs années, nous avions des chiffres clairs. Il en coûtait sept fois et demie plus si un patient consultait la clinique externe d'un hôpital plutôt que son médecin de famille. L'écart des coûts suscite des préoccupations.

Je conviens qu'il doit y avoir de la communication. Il faut créer l'occasion d'acquérir des connaissances. Cependant, je ne suis pas très sûre que la plupart des hôpitaux, même dans les plus petites communautés, seront encore là bien longtemps. Leurs services peuvent vraiment être fournis ailleurs dans la communauté. Le traitement des patients à l'hôpital est la méthode la plus coûteuse. Il y a moyen de traiter les gens ailleurs qu'à l'hôpital.

Les gens n'ont pas besoin de se rendre à l'hôpital pour recevoir des traitements. La plupart des médecins de famille et bien des spécialistes partagent mon avis. Les patients peuvent être traités hors de l'hôpital. Nous voudrions mettre fin à ce concept de «l'hôpital-hôtel».

Dans les provinces de l'Atlantique, on peut aller n'importe quand à l'hôpital pour constater que 30 ou 40 p. 100 des patients qui occupent des lits pourraient être traités ailleurs. Il nous faut changer cela.

Ceci m'amène à poser la question suivante: Que devraient faire les médecins? Comment peuvent-ils s'allier à leurs collègues spécialistes pour entretenir leur motivation à s'améliorer et à ne pas diriger leur cabinet en se fondant sur l'information que les trafiquants de drogue déposent à leur porte?

M. Scott: J'ajouterais qu'il y a plusieurs solutions. L'une serait que l'hôpital établisse une clinique de pratique en groupe qui fonctionnerait en conjonction avec l'hôpital. Une bonne partie des visiteurs «non urgents» des services d'urgence pourraient passer par ce système.

Une autre solution serait d'avoir de bonnes pratiques communautaires, qui ont de bonnes ententes d'affiliation avec l'hôpital. Cette approche pourrait englober aussi l'aspect éducatif. Cependant, il faudrait un autre mode de financement. Lorsque ce genre d'entente existe, on constate une différence remarquable.

D'après l'expérience que j'ai vécue dans le nord de l'Ontario et ses régions rurales, je préférerais encore consulter l'un de leurs médecins de famille surchargés qu'un médecin de Scarborough ou de Mississauga qui exerce seul. Les médecins des régions isolées collaborent bien ensemble. Ils comprennent que leurs patients ne tiennent pas à parcourir 250 milles parce que le médecin local n'a peut-être jamais vu un certain type de champignon. Par conséquent, les médecins ruraux font un effort supplémentaire pour se renseigner. Nous ne faisons pas assez, en tant que

I am totally convinced that fee for service should not be abolished. I believe that the answer lies in solid group practice arrangements.

Senator Michael Kirby (*Chairman*) in the Chair.

The Chairman: Mr. Scott, I apologize for being late.

Senator Keon: I came back to Canada when medicare came into force and have had a glorious life practising in this system. It is ideal for a doctor; there is no question about that. I had the great pleasure of working for a salary and was never concerned about what I made in a given day. My decisions were divorced from that kind of stress.

However, when I was young, I said over and over again at the Medical Research Council and everywhere else I pontificated that Canada needs a surgeon general who will report once each year on the state of the health of our nation — where the gaps are, what we are doing wrong, and where we must correct things — so that our aboriginal peoples and these “pockets” of terrible health services can be quickly responded to and corrected. I learned that this will never happen in the Canadian mosaic because it is politically unacceptable.

In talking with our chairman when the idea was spawned for this committee, I asked if he thought we would ever reach the stage where we could provide an annual report on the health of the nation — its strengths and weaknesses and where the problems are — and if that would ever be politically acceptable. I am not sure if he answered me; I think he is too smart for that. However, I would appreciate a response to that question if you would care to stick your neck out.

Mr. Scott: My answer to that is actually positive because I am a great believer in annual reports. For example, I believe that government agencies — the independent ones — should put out a report on the state of their organization. There should be an expectation around it. In this case, I believe it would be useful and might help to some degree, but I do not know that it would specifically help federal-provincial relations because both the federal government and the provinces could take their own angle on the reports and continue the war.

I think there would be some value, but I do not think that it would go to the root of solving federal-provincial issues, unless it was in conjunction with something else.

Senator Keon: I agree with the issues that you and Senator Robertson addressed. One of the hopes for a solution to the integration of our resources, in a reasonable way, lies in the electronic world. If we can reach the point where a patient gets one electrocardiogram each year instead of 10 or one X-ray per year instead of 10, and if we can reach the point where we have a

système, pour soutenir les médecins, particulièrement du côté des centres d'enseignement des sciences de la santé.

Je suis tout à fait convaincu que la rémunération à l'acte ne devrait pas être abolie. À mon avis, la réponse se trouve dans les ententes solides d'exercice collectif de la médecine.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

Le président: Monsieur Scott, je vous fais mes excuses pour mon retard.

Le sénateur Keon: Je suis revenu au Canada lorsque le Régime d'assurance-maladie a été créé, et j'ai eu une vie bien remplie d'exercice de la médecine dans le cadre de ce régime. Il est idéal pour un médecin; personne n'oserait dire le contraire. J'ai eu l'immense plaisir de travailler pour un salaire et je ne me suis jamais inquiété de savoir combien j'avais gagné une journée quelconque. Mes décisions n'étaient pas influencées par ce genre de préoccupation.

Cependant, quand j'étais jeune, j'ai dit à maintes reprises devant le Conseil de recherches médicales et partout ailleurs où j'ai pontifié que le Canada avait besoin d'un directeur de la santé qui rende compte une fois par année de l'état de la santé de notre nation — quelles sont les lacunes, ce que nous ne faisons pas bien et où il faut apporter des corrections — pour qu'on puisse réagir rapidement et corriger les problèmes de nos peuples autochtones et ces «zones» de très mauvais services de santé. J'ai appris que cela n'arriverait jamais sur la scène canadienne parce que c'est politiquement inacceptable.

Alors que je parlais avec notre président, lorsque l'idée a été lancée pour ce comité, j'ai demandé s'il pensait que nous arriverions jamais au stade où nous pourrions fournir un rapport annuel sur la santé de la nation — ses forces et ses faiblesses et où se trouvent les problèmes — et si ce serait un jour politiquement acceptable. Je ne suis pas sûr qu'il m'a répondu; je pense qu'il est trop malin pour ça. Cependant, j'apprécierais recevoir une réponse à cette question si vous voulez bien vous risquer.

M. Scott: La réponse que j'ai à vous donner est plutôt positive, parce que je suis un ferme partisan des rapports annuels. Par exemple, je crois que les organismes publics — les organismes indépendants — devraient présenter des rapports sur la situation de leur organisation. Des attentes devraient être formulées à cet égard. Dans ce cas-ci, je crois que ce serait utile et positif dans une certaine mesure, mais je ne pense pas que cela aiderait particulièrement les relations fédérales-provinciales, parce que tant le gouvernement fédéral que les provinces peuvent interpréter les rapports comme bon leur semble, et poursuivre la bataille.

Je pense donc que ces rapports pourraient être valables, mais pas qu'ils régleraient vraiment les problèmes entre les gouvernements fédéral et provinciaux à moins qu'une telle mesure soit soutenue par autre chose.

Le sénateur Keon: Je suis d'accord avec les problèmes que vous et le sénateur Robertson avez présentés. L'un des espoirs de solution à l'intégration de nos ressources, de façon raisonnable, réside dans le monde électronique. Si nous pouvons atteindre le point où un patient subit un électrocardiogramme chaque année plutôt que dix ou une radiographie par année plutôt que dix, et si

good electronic record that the patient owns and that follows the patient, it would help to deal with the privacy issues. I think that many of the problems we have had in trying to integrate primary care into secondary, tertiary and quaternary care would disappear. Would you comment on that? I spent a great deal of time with the various agencies, as well as the minister's committee, trying to get the health highway up and running. Bureaucratic stalls should not be a part of it.

Mr. Scott: I am a big booster of health information technology, but the state of health information is so bad that it is difficult to make an intelligent decision. When people debate that we cannot afford this system any longer, they may indeed be right, if they are projecting into the future the way this system currently operates.

My argument is that before we throw away the principles in this system, we should first be sure we are running the system properly and efficiently; but, we cannot do that because of our appalling lack of knowledge. For example, 16 years ago, when I was deputy minister, we regularly put submissions before cabinet requesting upgrades to the computer system. Each year, the bill became demonstrably bigger and each year the cabinet said, "Next year." In Ontario, we have experienced governments of all political stripes since that time and not one of them has modernized that system. As a consequence, while the system still adequately pays physicians, tonnes of information are collected that the government does not know what to do with. Ontario is not unique in these circumstances.

Until we have an electronic patient record, for example, and exchange information effectively, we will not have many efficiencies in the system. I predict that it will be a miracle if any of the money in this federal-provincial agreement leaks into any kind of coordinated information technology.

The Chairman: That last comment is fairly disconcerting.

Senator Kennedy: A branch of my own family, living in Orangeville, Ontario, has personally experienced the shortage of family physicians. To find a family physician for a growing family, you need to know someone who knows a doctor. Doctors are so overworked and so few in number that you might not find a family physician otherwise. If that situation exists in many other communities, it is no wonder the emergency departments are overflowing — people may not have any alternatives.

How do we medically accredit people with medical experience who come from other countries? The other day I listened to an interview with a doctor who came from another country five years ago. He is still not accredited in Canada. I do not know if there is a large pool of such doctors, but if there are people who have

nous pouvions arriver à créer un bon registre électronique, dont les dossiers appartiennent aux patients et les suivent, cela contribuerait vraiment à régler les questions de protection de la vie privée. Je pense que bon nombre des problèmes que nous avons connus en essayant d'intégrer les soins primaires aux soins secondaires, tertiaires et quaternaires disparaîtraient. Pourriez-vous donner votre avis là-dessus? J'ai passé beaucoup de temps avec les divers organismes, et aussi avec le comité du ministre, à essayer de concevoir et de mettre en marche l'autoroute de la santé. Les obstacles bureaucratiques ne devraient pas y avoir de place.

M. Scott: Je suis un grand défenseur de la technologie de l'information sur la santé, mais l'information sur la santé est en si mauvaise posture qu'il est difficile de prendre une décision judicieuse. Lorsque les gens soutiennent que nous n'avons plus les moyens de nous permettre ce système, ils ont peut-être raison s'ils voient l'avenir avec ce système tel qu'il est actuellement.

Ce que je pense, c'est qu'avant de rejeter les principes de ce système, il nous faudrait nous assurer que nous l'exploitons correctement et avec efficacité; cependant, notre consternante ignorance nous en empêche. Par exemple, il y a 16 ans, alors que j'étais sous-ministre, nous déposions régulièrement des soumissions devant le Cabinet pour demander la mise à niveau du système informatique. Chaque année, le document du projet de loi prenait visiblement de l'ampleur et, chaque année, le Cabinet nous disait «l'année prochaine». En Ontario, nous avons vu passer des gouvernements de toutes les tendances politiques depuis ce temps-là, et aucun d'eux n'a modernisé le système. Par conséquent, tandis que le système continue de rémunérer adéquatement les médecins, des tonnes de renseignements sont recueillis, dont le gouvernement ne sait que faire. L'Ontario n'est pas la seule dans cette situation.

Tant qu'il n'y aura pas de fichier électronique des patients, par exemple, et un échange efficace d'informations, le système ne pourra pas être efficient. À mon avis, ce sera un miracle si une moindre partie de l'argent prévu dans l'entente fédérale-provinciale est attribué à une quelconque mesure de coordination de la technologie de l'information.

Le président: Votre dernière observation est assez déconcertante.

Le sénateur Kennedy: J'ai de la famille qui vit à Orangeville, en Ontario, qui a personnellement été touchée par le manque de médecins de famille. Pour se trouver un médecin de famille, une famille qui grandit doit connaître quelqu'un qui connaît un médecin. Les médecins sont tellement débordés et si peu nombreux qu'il pourrait bien ne pas y avoir moyen de trouver un médecin de famille autrement. Si la situation est la même dans beaucoup d'autres communautés, il n'y a rien d'étonnant à ce que les services d'urgence débordent — les gens n'ont peut-être pas d'autre choix.

Comment pouvons-nous octroyer une accréditation médicale à des gens qui ont pratiqué la médecine à l'étranger? L'autre jour, j'écoutais une entrevue avec un médecin arrivé de l'étranger il y a cinq ans. Il n'a toujours pas été accrédité ici, au Canada. Je ne sais pas s'il y a beaucoup de ces médecins, mais s'il y a des gens qui

qualifications from elsewhere, perhaps it should not take so long to bring them up to our standards and methods. Do we deal with that issue or do we adopt almost a closed-door policy?

Mr. Scott: It is a pretty thorny question, and I will not pretend to be particularly knowledgeable about it. In the large urban areas we have a large number of physicians who were fully qualified in their native countries before coming to Canada. They run up against the standards that are established and applied to many of the Western countries, but not all of them. Canadian standards are not exactly Canadian — they are also American and British — so it is relatively easy to adjust between those.

I do not know how much of it is an adherence to standards and how much is protectionism. I would have thought that protectionism was much less than it was.

There is another problem. Assuming that the assessment is performed by a royal college, or equivalent, and a doctor from country X requires one year or one and one-half years to upgrade, where will the doctor get that upgrading? The inflexibilities of the academic health sciences centres are fairly serious at the moment. In the small rural communities and the under-served areas, we find that the doctors tend to develop a special interest, or special knowledge, or even a certificate in some area. One of the doctors may prefer to take an interest in obstetrics and prefer to do most of the births in the community. The other doctors may agree, provided there is an appropriate arrangement. Others will say that they would like to do more surgery.

There are upgrading programs available, but it is difficult to get a spot anywhere. That is a big problem in the medical schools, as well. It is not just a question of upgrading, but rather how and where the upgrading is to be done.

Senator Banks: I am from Alberta, and I am sure you are aware of some of the provincial government attitudes with respect to addressing these problems. I will ask you to comment on these attitudes and the likelihood that privatizing the provision of some services might be a way to improve the system, but I will ask you a larger question first.

The system, which everyone is trying to save, maintain, or improve, is almost mythical, one in which all Canadians have equal access to publicly provided health care. In the largest sense, and in your experience, can we afford such a system? Can we actually have this “thing” to which we would all aspire? Can we afford a universal public health system that covers all of the services that most of us think about? Are we after an impossible goal?

Mr. Scott: I do not believe that we are after an impossible goal. I believe that we can afford it — we have been able to afford it. When I look at the system today, I see duplication and waste. I am talking about a family physician who sees 50 patients each day —

ont acquis ailleurs les compétences nécessaires, peut-être qu'il ne faudrait pas tellement de temps pour les conformer à nos normes et à nos méthodes. Est-ce que nous envisageons cette possibilité, ou adoptons-nous une politique de porte quasi fermée?

M. Scott: C'est une question assez épineuse, et je ne prétendrai pas en savoir beaucoup dessus. Il se trouve, dans les grandes régions urbaines, beaucoup de médecins qui avaient toutes les compétences voulues dans leur pays d'origine, avant de venir au Canada. Ils se butent aux normes établies et appliquées dans bon nombre des pays occidentaux, mais pas partout. Les normes du Canada ne sont pas exclusivement canadiennes — elles sont aussi appliquées aux États-Unis et en Grande-Bretagne — et il est donc relativement aisé de s'y ajuster.

Je ne sais pas la part qu'a là-dedans la conformité aux normes et la part du protectionnisme. J'aurais pensé le protectionnisme beaucoup moins important.

Il y a un autre problème. Disons que l'évaluation est faite par un collège royal, ou l'équivalent, et qu'un médecin d'un pays X a besoin d'une année ou d'une année et demie de formation d'appoint, où recevra-t-il cette formation? Les centres d'enseignement des sciences de la santé ont très peu de flexibilité, en ce moment. Dans les petites communautés rurales et les régions où il manque de services, nous trouvons que les médecins tendent à manifester un intérêt particulier, ou à avoir des compétences spéciales, ou même à être diplômés dans un domaine spécialisé. Un médecin peut décider de s'intéresser particulièrement à l'obstétrique et faire la plupart des accouchements dans la communauté. Les autres médecins peuvent être d'accord, du moment qu'il y a une entente appropriée entre eux. D'autres préféreront faire la plupart des interventions chirurgicales.

Il existe des programmes de formation d'appoint, mais il est difficile d'y obtenir une place. C'est d'ailleurs un autre des gros problèmes des écoles de médecine. Ce n'est pas seulement une question de formation d'appoint, mais comment et où cette formation peut être obtenue.

Le sénateur Banks: Je viens de l'Alberta, et je suis sûr que vous connaissez les attitudes du gouvernement provincial vis-à-vis ces problèmes. J'aimerais que vous commentiez ces attitudes et la mesure dans laquelle la privatisation de la prestation de certains services pourrait améliorer le système, mais tout d'abord, j'aimerais poser une question plus générale.

Le système que tout le monde essaye de sauver, de maintenir ou d'améliorer, est presque un mythe; c'est un système où tous les Canadiens ont également accès aux soins de santé publique. Au sens le plus large, et d'après votre expérience, pouvons-nous nous permettre un pareil système? Pouvons-nous vraiment réaliser ce «rêve» que nous avons tous? Avons-nous les moyens d'avoir un système de santé publique universel qui couvre tous les services auxquels la plupart d'entre nous pensons? Cherchons-nous l'impossible?

M. Scott: Je ne crois pas que ce soit un but irréalisable. Je pense que nous pouvons nous le permettre — nous avons pu le faire jusqu'ici. Lorsque je regarde le système actuel, je vois du double emploi et du gaspillage. Prenons le médecin de famille qui

that is waste. In order to see that many patients in one day, many will be seen and referred to a specialist, when the family physician probably could have handled the matter, but not in an optimum way in relation to the fee schedule.

The standard complaint concerns repeated or duplicated treatment, such as everyone's comment about how often they have had their blood taken for the same reason. This references Dr. Keon's comment that there is no proper transfer of information, so treatment is repeated. These problems have long since been solved in industry through technology. This middle-level technology does not exist in the health care area.

Can I give you a guarantee that we can afford universal health care with full accessibility? I cannot give you that guarantee. When I look at the system and the way it currently operates, I do not believe that you ever receive savings from the system — the money requirement never comes down. It will take a fair amount of political courage at the federal and provincial levels to let that happen. It is more of a pragmatic political question.

In a practice sense, I believe the system is quite sustainable, but some of the political decisions that must be made are difficult. If \$100 million is spent to upgrade the OHIP system in Ontario, that does not cure one patient in the short term. However, if there is an announcement expanding the emergency wings in six community hospitals in southwestern Ontario, that is worth many seats. That is where the trade-off is, as far as I am concerned.

Senator Banks: We are being softened up in our part of the world to accept that we will have a health system, but services and provisions will be carved out of it. The health system, to the extent that it remains universal and accessible, will offer fewer kinds of treatment. Is that not necessary if the political will can be found to make the systemic changes that must be made?

Mr. Scott: Some adjustments like that are probably worthwhile. There are old procedures and practices that we probably should not be paying for any more. Some people will argue that much of the cosmetic surgery, for example, should not be paid for any longer and should not be a priority. While there is room for reform in that area, that is not the place to start. No one should expect that reform will yield anything like the kind of results that I believe we want to accomplish within the system.

I draw a distinction between private health care and the involvement of the private sector in health care. Close to 40 per cent of our private health care money now goes to private sector delivery systems. Thus, I am not opposed to the private sector being more involved in health care, but the policy control must remain at the public level, not in the hands of the private deliverers.

voit 50 patients chaque jour — ça, c'est un gaspillage. Pour voir autant de patients en une journée, un médecin doit en envoyer beaucoup vers des spécialistes, alors qu'il pourrait probablement régler le problème, mais pas d'une façon optimale par rapport au barème d'honoraires.

Une plainte qu'on entend souvent formuler concerne les traitements répétés ou qui se chevauchent, comme tous ces gens qui disent combien de fois ils ont eu des prises de sang pour les mêmes raisons. Ceci revient aux commentaires du Dr Keon, qui dit qu'il n'y a pas de transfert approprié de l'information, alors le traitement est répété. L'industrie a résolu ces problèmes depuis longtemps, grâce à la technologie. Cette technologie du niveau intermédiaire n'existe pas dans le domaine des soins de santé.

Est-ce que je peux vous garantir que nous pouvons nous permettre un régime de santé universel pleinement accessible? Non, je ne peux pas vous le garantir. Lorsque je regarde le système et la façon dont il fonctionne actuellement, je ne pense pas qu'il permettra jamais des économies — l'exigence monétaire n'est jamais comblée. Il faudrait pas mal de courage politique, tant au niveau fédéral que provincial, pour que cela puisse arriver. La question est plutôt d'ordre politique pragmatique.

Sur le plan pratique, je pense que le système est assez soutenable, mais il y a des décisions politiques assez difficiles à prendre. Si on met 100 millions de dollars sur la mise à niveau du système de Protection-santé de l'Ontario, cela n'apporte pas la guérison à court terme à un patient. Cependant, si on annonce l'expansion des services d'urgence de six hôpitaux communautaires du sud-ouest de l'Ontario, ça pourrait coûter pas mal de sièges. C'est là que se trouve le compromis, à mon avis.

Le sénateur Banks: On essaie de nous convaincre, dans notre partie du globe, d'accepter un système de santé dont des services et des soins seront supprimés. Le système de santé, pour demeurer universel et accessible, offrira un éventail plus limité de traitements. Est-ce que ce n'est pas nécessaire, si on peut trouver la volonté politique d'effectuer les changements systémiques qui s'imposent?

M. Scott: Certains ajustements du genre en valent probablement la peine. Il y a des procédures et des pratiques qui ne devraient probablement plus être payées. Certaines personnes soutiendraient que les traitements de chirurgie esthétique, par exemple, ne devraient plus être payés, ni constituer une priorité. Bien qu'il y ait de la place pour une réforme dans ce domaine, ce n'est pas là qu'il faut commencer. Personne ne devrait s'attendre à ce que la réforme donne le genre de résultats que, il me semble, nous voulons atteindre dans le système.

Je fais une distinction entre les soins de santé privés et la participation du secteur privé aux soins de santé. Près de 40 p. 100 de nos subventions aux soins de santé privés sont actuellement versées dans les systèmes de prestation de services du secteur privé. Donc, je ne m'oppose pas à une plus grande participation du secteur privé aux soins de santé, mais le contrôle des politiques doit rester entre les mains de l'État, et non pas du secteur privé.

The Chairman: Mr. Scott, in response to Senator Banks, you said two or three times that the system is sustainable provided the political will exists to address the difficult questions. The illustrative example you used was putting money into an electronic information system rather than into emergency room development. Can you give us a few other examples of what you would call the really tough political questions that need to be answered?

Mr. Scott: I think the biggest problems occur when dealing with providers and changing the environment around which these providers work. I talked about alternative funding plans.

The Chairman: When you say "providers," is that a code word for physicians?

Mr. Scott: It is broader than that — it encompasses nurses and other paramedical personnel as well.

We have working groups in place in a number of the teaching hospitals and in a few of the large community hospitals. Instead of the traditional hierarchy where the physician was in charge, the physician is now part of a team that involves nurses, technicians, and so on. The different teams do different work, which improves the environment considerably.

There is enormous opposition to the broadening of that kind of exercise, which begins to manifest itself even when we get into alternate payment plan, or APPs. It seems to me that to have a good community alternate payment plan — an ultimate funding mechanism — we ought not to be providing just for the doctors but also for the nurses in all professional categories. There is still much institutional opposition to that idea. In fact, it is not unusual for the government to suggest that it is unwilling to take that plan on when it has so many other related issues that require solutions, such as negotiating current fee schedules or remuneration structures.

The Chairman: In essence, your concern is that when there is a crisis, we will deal with it and not worry about taking steps toward a long-term solution that might help to avoid a future recurrence of that crisis.

Mr. Scott: Yes. That is why I felt that while it is a simple answer, it is a difficult solution to implement. The reason is that if a province were to spend that money on information technology with no immediate payback and, as a result, the public were to become upset by this, would a federal government defend the provincial government's spending actions or would they simply say, "We gave them the money and they should be able to manage it effectively to solve the problem"? Some sense of joint accountability must be achieved or those problems will not be eliminated, especially on the eve of an election.

The Chairman: Politics is the art of shifting the blame, and if you can leave everyone with someone else to whom they can shift it or shift it into some other form that is hard to pin down, that is always helpful.

Le président: Monsieur Scott, en réponse au sénateur Banks, vous avez dit deux ou trois fois que le système est soutenable à partir du moment où il y a une volonté politique de régler les questions difficiles. Pour donner un exemple, vous avez parlé de mettre l'argent dans un système d'information électronique plutôt que dans l'expansion des salles d'urgence. Pouvez-vous donner quelques autres exemples de ce que vous appelez les questions politiques très difficiles qui doivent être résolues?

M. Scott: Je pense que le plus gros problème est de traiter avec les prestataires de services et modifier l'environnement dans lequel ils fonctionnent. J'ai parlé d'autres modes de financement.

Le président: Lorsque vous parlez de «prestataires de services», est-ce un mot de code pour désigner les médecins?

M. Scott: C'est plus que ça — ce sont aussi les infirmiers et infirmières et les autres membres du personnel paramédical.

Nous avons des groupes de travail dans plusieurs hôpitaux d'enseignement et quelques grands hôpitaux communautaires. Au lieu de la hiérarchie traditionnelle qui met les médecins en charge de tout, celui-ci fait maintenant partie d'une équipe qui englobe les infirmières, les techniciens, et cetera. Chaque équipe a ses tâches particulières, ce qui améliore grandement l'environnement.

Il y a une résistance énorme à l'expansion de ce mode de fonctionnement, résistance qui commence à se manifester même lorsqu'on parle d'autres modes de paiement. Il me semble que, pour avoir un bon plan de rechange de paiement communautaire — un mécanisme de financement ultime — il nous faut non seulement prévoir des mesures pour les médecins, mais aussi pour les infirmiers et infirmières de toutes les catégories professionnelles. Il y a encore pas mal de résistance institutionnelle à ce concept. En fait, il n'est pas inhabituel pour le gouvernement de laisser entendre qu'il n'est pas prêt à s'attaquer à ce plan tant qu'il reste encore tellement de questions connexes à résoudre, comme la négociation des barèmes d'honoraires ou des structures de rémunération.

Le président: En fait, ce qui vous préoccupe, c'est que lorsqu'il y a une crise, nous composons avec elle sans nous occuper de prendre des mesures visant une solution à long terme qui pourrait contribuer à éviter une répétition de cette crise.

M. Scott: Oui. C'est pourquoi je pense que bien que la réponse soit simple, c'est une solution difficile à mettre en oeuvre. La raison à cela est que, si une province consacrait ce genre de somme à la technologie de l'information sans qu'il y ait de retombée immédiate et que le public s'en montrait choqué, est-ce que le gouvernement fédéral prendrait la défense des décisions du gouvernement provincial en matière de dépense, ou est-ce qu'il dirait tout simplement: «Nous leur avons donné l'argent et ils devraient être capables de résoudre le problème avec efficacité»? Il faut une certaine dose d'imputabilité conjointe, sinon ces problèmes ne disparaîtront pas, surtout à la veille d'élections.

Le président: La politique est l'art de rejeter la faute sur quelqu'un d'autre, et si on peut donner à tout le monde quelqu'un d'autre sur qui la rejeter ou un moyen de la transformer de manière à ce qu'elle ne puisse pas être attribuée à personne, c'est toujours utile.

Mr. Scott: This has been the high art of health care. Because of the cuts the federal government made in the mid-1990s as part of its strategy to deal with the debt and the deficit, for the first time in my memory the public began to conclude that maybe the federal government did have an impact on the quality of what was being delivered at the provincial level. While the provinces still carry the bulk of the credit and the blame for things that go right or wrong in the health care system, I think the federal government will find it harder and harder to be as aloof as it used to be when it could simply say "You are not doing the right things." If that happens, maybe that will bring them together. When I was involved with environment issues, I saw a fair amount of cooperation federally and provincially on the issue of acid rain, for example.

The Chairman: The public blamed each government equally.

Mr. Scott: Yes.

The Chairman: In health care, they have been much less inclined to do that to date.

Senator Banks: There is a third element to which you have referred — and I am sure there are fifty elements — namely, institutional resistance. I presume that would include the institution of a hospital and the hospital's management as well as the hospital district, or however it is done from province to province. It also involves the professions, does it not? Can the medical profession be convinced, subsumed or co-opted into going along with the systemic changes that must be made in order to fix the problem?

Community health systems have been tried in Ontario and in Quebec, and there was great resistance to them on the part of physicians in particular. How can you see that we might break that resistance down?

Mr. Scott: The recent Ontario Medical Association-Government of Ontario agreement on payment of fees opened the door in a big way to alternate payment plans. Five years ago the Ontario Medical Association would have said no, a thousand times no. They then moved to a position where they would consider the plan, but it had to be good and it had to include these payment plans. They are now acting as partners with the government in the design and structuring of these programs. That will advance it.

Most professions can be dealt with one on one, but it is a complex thing to do. When I was deputy minister in 1984, the then minister established a review of the health professions legislation in Ontario to bring some order out of the chaos about the borderlines between all the professional groups. The ministry started off with everyone from dental assistants, hygienists, denturists, and so on, to figure out whether they should have independent governance, what role they should have, what regulatory powers they should have, and so on. That process began in 1984 and legislation was passed in 1995. If you really

M. Scott: C'était le grand art dans le domaine des soins de santé. Quand le gouvernement fédéral a imposé des compressions au milieu des années 90, dans le cadre de sa stratégie visant la dette et le déficit, ça a été la première fois, si ma mémoire ne me trompe pas, que le public a pris conscience que, peut-être, le gouvernement fédéral avait une influence sur la qualité des services offerts au niveau provincial. Même si les provinces continuent de recevoir le plus gros des éloges et des reproches pour ce qui va bien ou mal dans le système de santé, je pense que le gouvernement fédéral commencera à trouver de plus en plus difficile de continuer de dire, l'air détaché, «vous ne faites pas les choses comme il faut». S'il le fait, peut-être que cela rapprochera les provinces. Lorsque je m'occupais de questions d'environnement, j'ai vu une bonne coopération entre les provinces et le gouvernement fédéral, sur les questions des pluies acides, par exemple.

Le président: Le public faisait autant de reproches à chaque gouvernement.

M. Scott: Oui.

Le président: Au sujet de la santé, il a eu nettement moins tendance à le faire jusqu'ici.

Le sénateur Banks: Il y a un troisième élément dont vous avez parlé — et je suis sûr qu'il y en a au moins 50 — c'est la résistance institutionnelle. Je présume que cela englobe l'institution d'un hôpital, la gestion de l'hôpital et le district hospitalier, ou l'équivalent, selon la façon dont les choses se font d'une province à l'autre. Cela englobe aussi les professions, n'est-ce pas? Est-ce que la profession médicale peut être convaincue ou obligée d'adhérer aux changements systémiques qui doivent être adoptés pour régler le problème?

L'Ontario et le Québec ont fait l'essai des systèmes de santé communautaires, et cela a suscité une résistance phénoménale, de la part des médecins en particulier. Comment pensez-vous qu'il soit possible de vaincre cette résistance?

M. Scott: L'entente conclue récemment entre l'Ontario Medical Association et le gouvernement de l'Ontario au sujet du versement des honoraires a ouvert largement la porte aux plans visant d'autres modes de rémunération. Il y a cinq ans, l'Ontario Medical Association aurait dit non, mille fois non. Puis elle a modifié son attitude et a accepté d'examiner le plan, mais il fallait que celui-ci soit bon et qu'il englobe ces plans de paiement. Ils agissent maintenant en partenariat avec le gouvernement dans la conception et la structuration des programmes. Ainsi des progrès pourront-ils être réalisés.

On pourrait traiter ainsi avec la plupart des professions, une à une, mais c'est une entreprise complexe. Lorsque j'étais sous-ministre, en 1984, le ministre de l'époque a commandé une révision des lois régissant les professions de la santé en Ontario afin de mettre de l'ordre dans la pagaille des frontières entre tous les groupes professionnels. Le ministère s'est mis à examiner toutes les professions, des assistants aux hygiénistes dentaires en passant par les prothésistes, et cetera, dans le but de déterminer s'il leur fallait un régime indépendant de gestion, quel rôle ils devraient avoir, quels pouvoirs de réglementation, et cetera. Ce

believe that the borders have been sorted out, then you can spend some time explaining it to me.

The reality is that everyone steps on the hand of the person on the ladder behind them within the health care system.

Senator Cohen: I wanted to talk about New Brunswick's extramural hospital, which Senator Robertson initiated when she was minister of health, and how effective that instrument is as a separate institution. I was twice the recipient of the care of that hospital. I had surgery in Nova Scotia and then returned to Saint John, never having to see a surgeon again because of the nurses at the extramural hospital. They were so efficient and so caring and were in constant contact with the doctor in Halifax. My care was excellent and efficient. This innovative hospital is still in existence in New Brunswick. Why is an institution like the extramural hospital not considered by governments across the country? I know there is a lack of nurses, but we have not grown with this concept.

Mr. Scott: I do not know a great deal about the extramural hospital, but the problem goes back to the issue of billing authority. I will get into trouble for saying this, but things such as well-baby visits probably do not need to be done by doctors at all. Many doctors do not even like doing them, but they pay not badly in the fee schedule. It is happy moment for a doctor to see a healthy, happy baby as opposed to all the other problems they see on a daily basis. I have had doctors in rural areas tell me that they do deliveries so that they will be able to have the fee schedule payment for well-baby visits for the next three years. As long as we are driving well-educated doctors down into a fee schedule to practise in areas that do not challenge them, we are making life less interesting for most doctors. They are "A" personalities and they are looking for a challenge. Not only are we not making proper use of our doctors, but that is filtering down to the nurses. Nurses cannot perform certain duties because if they do, they will become a threat to the income made by doctors.

The Ontario Medical Association has been struggling to change the fee schedule for some time and put it on a value base, but the OMA is a political association and must deal with its internal politics. The moment you try to change the entitlements, they are probably much less flexible than most elected governments.

Senator LeBreton: Would the answer be to radically restructure the fee schedule to force that kind of situation, or would doctors not agree? Would it not be in their best interest to restructure a fee schedule so that they receive a higher fee for the serious work they do and a lower fee for work such as the

processus a été lancé en 1984 et les mesures législatives ont été adoptées en 1995. Si vous pensez vraiment que les frontières entre les professions ont été définies, peut-être pourriez-vous vous donner la peine de me les expliquer.

La réalité, c'est que chacun met le pied sur les mains de la personne qui le suit sur l'échelle, dans le système de soins de santé.

Le sénateur Cohen: Je voudrais parler de l'Hôpital extra-mural du Nouveau-Brunswick, que le sénateur Robertson a mis sur pied lorsqu'elle était ministre de la Santé, et de l'efficacité de cet instrument, en tant qu'institution séparée. J'ai reçu à deux reprises des soins à cet hôpital. J'ai subi une opération chirurgicale en Nouvelle-Écosse, puis je suis retourné à Saint John, et je n'ai jamais eu à revoir un chirurgien, grâce aux infirmières de l'hôpital extra-mural. Elles ont été très efficaces et très dévouées, et elles maintenaient une communication constante avec le médecin d'Halifax. J'ai reçu d'excellents soins, très efficaces. Cet hôpital innovateur existe encore au Nouveau-Brunswick. Pourquoi le gouvernement n'envisage-t-il pas de créer des hôpitaux extra-muraux dans tout le pays? Je sais qu'il manque d'infirmiers et d'infirmières, mais ce concept n'a jamais été poussé.

M. Scott: Je n'en sais pas beaucoup sur l'hôpital extra-mural, mais le problème vient de l'autorité de facturation. Je vais me créer des problèmes en disant cela, mais il y a des choses comme les visites des enfants bien portants, qui n'ont pas besoin d'être effectuées par des médecins. Beaucoup de médecins n'aiment même pas les faire, mais ces visites paient bien dans le barème de rémunération. Et puis c'est un moment agréable pour un médecin de voir un bébé en santé et heureux, comparativement aux autres problèmes qu'ils voient quotidiennement. Il y a des médecins de régions rurales qui m'ont dit qu'ils faisaient des accouchements rien que pour recevoir les honoraires des visites d'enfants bien portant pendant les trois années qui suivent. Tant que nous pousserons des médecins compétents à compter sur un barème d'honoraires et à pratiquer leur profession dans des domaines qui ne les stimulent pas, nous leur rendons la vie moins intéressante. Ce sont des gens qui ont besoin de défis à relever. Non seulement nous n'utilisons pas nos médecins à bon escient, mais cela se répercute sur les infirmiers et infirmières. Les infirmiers et infirmières ne peuvent pas remplir certaines fonctions parce que s'ils le font, ils deviennent une menace pour les revenus des médecins.

L'Ontario Medical Association fait des pieds et des mains depuis quelque temps pour modifier le barème de rémunération de manière à le fonder sur la valeur du service, mais c'est une association politique et elle doit composer avec sa politique interne. À partir du moment où on essaie de changer quelque chose aux droits des membres, ils se montrent probablement beaucoup moins flexibles que la plupart des gouvernements élus.

Le sénateur LeBreton: Est-ce que la solution serait de restructurer radicalement le barème de rémunération pour imposer ce genre de situation, ou est-ce que les médecins s'y opposeraient? Ne serait-il pas de leur intérêt de restructurer le barème de manière à ce qu'ils reçoivent plus pour les tâches difficiles qu'ils

well-baby visits? Would that not force the system into responding to these issues?

Mr. Scott: The Ontario Medical Association has been trying to do that among their members for several years now. Every year, the report is to come out the next year. I am sure they will get a report out, but it probably will not do a great deal. It is difficult for them, and I am not being critical. Over the years, when the Ontario government negotiated with the OMA, it did not change the fee schedule. It said, "You received X number of billions last year and you will get X number of billions plus \$400 million this year." The physicians sat down and adjusted the money across the fee schedule.

If family doctors had said they had been getting short shrift since the last agreement and the psychiatrists were making a killing, then more of that \$400 million would go into fee schedule items that family practitioners would use more often and less, or maybe none, to psychiatrists. The orthopaedic doctors may have then been upset, feeling they did not get enough money, and their fees would have been adjusted the next time around.

It is a terribly political exercise. Ontario governments have never wanted to touch it with a 10-foot pole because they have not had the expertise. They know that all they can do is get into trouble. The poor OMA has the same problem politically. In fact, one of the sections — the radiologists, I believe — has sued the OMA over their handling of this kind of matter. That is why my solution tends to push more away from fee for service.

In community clinics — and there is good evidence of this — physicians tend to do the things they want to do and work out arrangements with their colleagues. As a result, when they go to hire another physician to join their group, they know exactly what they are looking for and what to do. Work then becomes more pleasurable. There is no reason for it to be less rewarding because it is not driven by a series of artificial items and time.

From a patient's point of view, if you have a complex series of problems and one or two consultations a year before you run outside of the 20 minutes, that will not do you much good.

Senator Fairbairn: In much of what Mr. Scott has said, and particularly in the last conversation, an interminable circle appears to be impeding progress on so many fronts, whether it is service or the income that people make. The question is this: How do we break through that circle? We are working at a certain political level, but in listening to you talk, we hear that there is equally as vibrant a political level within the professional groups themselves.

That is more of a comment than a question because I do not believe you have the answer; I am not sure anyone does. However, clearly it is a major part of the larger issue when we are talking about quality and the availability of human resources.

accomplissent et moins pour les choses comme les visites d'enfants bien portants? Est-ce que cela ne forcerait pas le système à régler ce genre de problème?

M. Scott: Cela fait déjà plusieurs années que l'Ontario Medical Association essaye de le faire avec ses membres. Chaque année, la remise du rapport est reportée à l'année suivante. Je suis sûr qu'un rapport finira par être présenté, mais il ne fera probablement pas grand-chose. C'est difficile pour eux, et je ne veux pas les critiquer. Au fil des années, lorsque le gouvernement de l'Ontario a négocié avec l'Association, il n'a jamais touché le barème de rémunération. Il disait: «Vous avez reçu tant de milliards de dollars l'année dernière, vous en recevrez tant, plus 400 millions de dollars cette année.» Les médecins s'assoient alors ensemble et répartissaient l'argent dans tout le barème de rémunération.

Si les médecins de famille avaient dit qu'ils avaient été lésés depuis la dernière entente tandis que les psychiatres se remplissaient les poches, alors la plus grande partie de ces 400 millions de dollars était attribuée à des éléments du barème de rémunération des services le plus souvent fournis par les médecins de famille et moins, sinon rien, allait aux psychiatres. C'est alors que les médecins orthopédiques protestaient et disaient qu'ils ne recevaient pas assez d'argent, et alors leurs honoraires étaient ajustés la fois suivante.

C'est un exercice terriblement politique. Le gouvernement de l'Ontario n'a jamais voulu y toucher parce qu'il n'a pas l'expertise qu'il faut pour cela. Il sait que tout ce qu'il peut faire, c'est se mettre les pieds dans les plats. La pauvre Ontario Medical Association a le même problème, politiquement parlant. En fait, l'une de ses sections — les radiologues, je crois — a traîné l'OMA en justice à cause de sa façon de composer avec ce genre de questions. C'est pourquoi je propose qu'on s'éloigne de la rémunération à l'acte.

Dans les cliniques communautaires — il y a des preuves — les médecins tendent à faire ce qu'ils veulent faire, et à s'entendre avec leurs collègues. Par conséquent, lorsqu'ils recrutent un autre médecin pour se joindre à leur groupe, ils savent exactement ce qu'ils cherchent et quoi faire. Le travail devient alors plus agréable. Il n'y a pas de raisons pour que ce soit moins gratifiant, parce que ce n'est pas commandé par une série de motifs artificiels et par le temps.

Du point de vue des patients, si vous avez un paquet de problèmes et une ou deux consultations par année qui ne dépassent pas 20 minutes, cela ne vous donne pas grand-chose.

Le sénateur Fairbairn: Avec tout ce qu'a dit M. Scott, et particulièrement ses dernières observations, il semble qu'un cycle interminable fasse obstacle au progrès sur tellement de plans, que ce soit au sujet du service ou des revenus des gens. La question qui se pose est la suivante: comment rompre ce cycle? Nous travaillons à un certain niveau politique, mais à vous entendre, l'aspect politique n'est pas moins déterminant dans les groupes professionnels eux-mêmes.

C'est plus une observation qu'une question, parce que je ne crois pas que vous ayez une réponse à offrir; je ne suis pas sûre que quiconque en aie. Cependant, c'est un élément important de la question plus vaste, lorsque nous parlons de qualité et de

There is an impediment to new thinking entering the system right now because of all of the structures that have been in place for a long time. I suppose some critics would also say that this includes the Canada Health Act.

Senator Banks asked a question that I will also ask. What are your thoughts on the situation in the province of Alberta with the new law that has yet to be played out? Does this new law, Bill C-11, concern you in your views of the relationship between private sector involvement and delivery of service? Do you have a concern about that legislation, as it now has come into law?

Mr. Scott: I will begin by saying that I am not an expert on the legislation. I certainly was not of the opinion that it breached the Canada Health Act, but I would like to see if it can work. I am somewhat skeptical that this structure will prove to be more efficient. We always have problems measuring efficiency between government and the private sector and who counts what. However, I have some hesitation in believing that this initiative will turn out to be more efficient.

On the other hand, I believe that one ought to at least test these things and see if these delivery systems work better. My understanding of that system is that the government still has political control, so if it does not work then the government can stop it.

That is one of the problems. We must do more experimentation. I do not claim to know enough to say whether that is the right experiment or not. I would be reluctant just to say no or that it cannot be tried.

Senator Fairbairn: One of my questions is in relation to the system of control, which will not really be tested until there is a breach in the way that system operates. That has been the concern all along. Once it gets rolling, it will take on a life of its own. The interesting point will be the degree of control that can be maintained. I wanted to raise that point because it is troublesome to many people on both sides of the issue.

Another situation bothers me. You come from a province of large rural areas and huge distances between small communities. I come from a province that has two major centres and then there is the rest of the province. I do not wish to discount my own city, which is the third largest, but there is quite a difference in population.

What do we do when even electronic assistance cannot be of a great deal of help to a small community that simply — and this is happening — cannot attract a doctor? We do not have a process in this country to address that problem.

My colleague mentioned the process of accrediting people coming from outside of Canada. This is undoubtedly an area where there is a great deal of frustration at the length of time it takes to certify qualified people or for them to gain access to the required upgrading. They sometimes give up altogether. In many cases, people with skills would probably find it acceptable to go to a smaller community but cannot do so because of these difficulties.

disponibilité des ressources humaines. Il y a une résistance à l'avènement d'un nouveau mode de pensée dans le système en ce moment, à cause de toutes les structures qui sont en place depuis longtemps. Je suppose que certains critiques iraient jusqu'à dire que la Loi canadienne sur la santé en fait partie.

Le sénateur Banks a posé une question que j'aimerais, moi aussi, poser. Que pensez-vous de la situation en Alberta, avec la nouvelle loi dont on n'a pas encore vu les effets? Est-ce que cette nouvelle loi, la loi C-11, vous préoccupe, selon la perspective que vous avez du rapport entre la participation du secteur privé et la prestations des services? Est-ce que cette loi vous inquiète, maintenant qu'elle est en vigueur?

M. Scott: J'aimerais commencer par dire que je ne suis pas spécialiste de cette législation. Je n'ai certainement jamais pensé qu'elle allait à l'encontre de la Loi canadienne sur la santé, mais j'aimerais savoir si elle peut marcher. Je ne suis pas sûr que cette structure s'avère plus efficace; nous avons toujours eu de la difficulté à évaluer l'efficacité entre le gouvernement et le secteur privé et à savoir qui fait le compte de quoi. Toutefois, j'hésite à croire que cette initiative se révèle plus efficace.

Par ailleurs, il me semble que l'on devrait au moins essayer pour voir si ces systèmes de prestation fonctionnent mieux. Si je comprends bien, le gouvernement conserve le contrôle politique de ce système et peut y mettre un terme s'il ne fonctionne pas.

C'est l'un des problèmes. Il faut faire plus d'essais. Je ne prétends pas en savoir suffisamment pour dire s'il s'agit de la bonne solution ou non. J'hésiterais à répondre simplement par la négative ou à dire qu'elle ne peut pas être mise à l'essai.

Le sénateur Fairbairn: Une de mes questions porte sur le système de contrôle qui ne sera pas vraiment mis à l'essai à moins qu'il n'y ait violation du fonctionnement du système. C'est ce qui a toujours posé problème. Une fois le système mis en place, il sera difficile de le contrôler. Il serait intéressant de connaître le degré de contrôle qui peut être exercé. Je voulais soulever cette question, car elle est difficile pour beaucoup de personnes des deux côtés.

Une autre situation m'inquiète. Vous venez d'une province où les distances entre petites localités sont immenses. Je viens d'une province qui compte deux grands centres urbains, en plus du reste. Je ne cherche pas à rabaisser ma propre ville qui est la troisième en importance, mais où la différence en matière de population est marquée.

Que faire lorsque des mécanismes d'aide électronique ne peuvent pas vraiment répondre aux besoins d'une petite localité qui tout simplement — et c'est ce qui se passe — ne peut pas attirer un médecin? Nous n'avons pas de processus dans notre pays pour régler ce problème.

Mon collègue a fait mention du processus d'agrément des personnes qui viennent de l'étranger. C'est évidemment un domaine où il y a beaucoup de frustration vu le temps qu'il faut pour agréer des personnes qualifiées ou pour qu'elles puissent avoir accès au perfectionnement requis. Il arrive qu'elles abandonnent tout. Dans de nombreux cas, les personnes compétentes trouveraient probablement acceptable de s'installer dans une petite localité, mais elles ne peuvent pas le faire à cause de ces difficultés.

Mr. Scott, what can we do in areas of the country that have a shortage of doctors simply because their income demands cannot be met or there is a lack of services for their families? It is happening in Canada and in my part of Canada. Desperate communities that are far enough away from Lethbridge, and certainly Calgary or Edmonton, simply do not have physician health care or are on the verge of losing it. For example, a doctor may have been hard at it for 40 years and simply cannot continue working. It is a fearful thing that no one wants to come into these areas.

Mr. Scott: In 1995, I delivered a full report to the Rae government on that subject. In 1993, not only were physicians leaving under-served areas in fairly large numbers, but those who were staying were demanding supplementary income to provide on-call services at the hospitals. I went on quite an extensive tour of the province and talked to doctors in all those communities, following which I produced a report that I believe contained some of the answers.

First, when I looked at the overall remuneration, those doctors were not doing badly — that is, of course, because they were working 24 hours a day, seven days a week.

Generally speaking, doctors wanting more money was more a manifestation of anger and frustration about their working conditions than the fact that they may have wanted more money. It may have been exacerbated by seeing their classmates in Mississauga working nine to five and sending everyone to emergency after five o'clock, when most people come home from work and want to see a doctor.

The answer lies entirely in lifestyle. You will find Toronto-born-and-bred physicians who are happily ensconced in Pickle Lake, Red Lake and Rainy River. They will move for the lifestyle, but they do not have an opportunity to experience the lifestyle they went there to get.

That is the reason that I first became enthusiastic for an alternative payment plan. Sioux Lookout and Dryden had stability in physician services, yet conditions were the same as other communities. The physicians there put together a group practice. They had an arrangement whereby they cooperated on their fee-for-service earnings. They had separate but collegial practices. They divided the responsibilities among themselves. They found life more enjoyable and therefore had fewer turnovers. When they went out to recruit, they had greater success recruiting. An APP makes it better because you can do the things you want to do in cooperation with the other doctors in the community. You would not be penalized because your interest is in mental health and not in well babies, which pay better in certain parts of the fee schedule.

Senator Fairbairn: You are presuming that there are other doctors in the community.

Monsieur Scott, que peut-on faire dans les régions du pays où il y a pénurie de médecins simplement parce qu'il est impossible de répondre à leurs exigences en matière de revenu ou parce que leurs familles n'auront pas accès à certains services? C'est ce qui se passe au Canada et dans ma région. Des localités désespérées, trop éloignées de Lethbridge, et certainement de Calgary ou d'Edmonton, n'ont tout simplement pas accès à un médecin ou sont sur le point de le perdre. Par exemple, il se peut qu'un médecin ait travaillé sans relâche dans cette localité pendant 40 ans et qu'il ne peut tout simplement pas continuer. Il est effrayant de voir que personne ne veut venir dans ces régions.

M. Scott: En 1995, j'ai présenté un rapport au gouvernement Rae sur le sujet. En 1993, d'assez nombreux médecins quittaient les régions où il n'y en avait déjà pas assez, tandis que ceux qui restaient exigeaient un revenu supplémentaire pour assurer des services de garde dans les hôpitaux. Je me suis rendu dans toutes les régions de la province pour les rencontrer, à la suite de quoi j'ai publié un rapport qui, selon moi, renfermait certaines des réponses.

J'ai commencé tout d'abord par examiner la rémunération globale des médecins; ces médecins s'en tiraient relativement bien — parce qu'ils travaillaient 24 heures par jour, sept jours par semaine.

En général, lorsqu'ils disaient vouloir plus d'argent, les médecins manifestaient en fait leur colère et leur frustration à l'égard de leurs conditions de travail. Cela a pu être exacerbé par le fait qu'ils voyaient leurs collègues de Mississauga travailler de 9 à 5 et envoyer tous les patients aux urgences après 5 heures, lorsque la plupart des gens reviennent du travail et veulent voir un médecin.

La réponse se trouve uniquement dans le mode de vie. Vous avez des médecins nés et élevés à Toronto qui sont très bien installés à Pickle Lake, Red Lake et Rainy River. Ils sont prêts à déménager pour le mode de vie, mais ils n'ont pas la possibilité de vivre celui qu'ils recherchent.

C'est la raison pour laquelle je suis devenu fortement en faveur d'un mode de paiement alternatif. Je me suis aperçu que les services de médecin à Sioux Lookout et à Dryden étaient stables alors que les conditions étaient équivalentes à celles d'autres localités. Les médecins dans ces villes-là ont instauré une pratique collégiale. Dans le cadre de leur entente, ils adoptent une approche coopérative à l'égard des honoraires à l'acte. Leur pratique est distincte tout en étant collégiale. Ils se répartissent les responsabilités et ont découvert que la vie est plus intéressante, ce qui entraîne moins de roulement. Lorsqu'ils vont recruter, ils ont plus de succès que d'autres localités. Un MPA améliore les choses, parce qu'il est possible de faire ce que l'on veut en coopération avec les autres médecins de la localité. On ne se retrouve pas pénalisé du fait que l'on s'intéresse à la santé mentale et non à la santé des bébés, qui rapporte mieux selon certains éléments du barème des honoraires.

Le sénateur Fairbairn: Vous présumez qu'il y a d'autres médecins dans la localité.

Mr. Scott: Yes. In a community that has a hospital, we cannot expect to maintain any stability in physician services if we have less than five doctors. It is iffy with five doctors or six doctors. However, if all of the conditions are right, if there is some understanding in the community, and if we make greater use of nurse practitioners and others, perhaps we could sustain some stability in the community. It could not happen with fewer than five doctors.

The most energetic young doctors get burned out after two or three years. The iron horses tend to drive away new doctors because the iron horses tend to be dominant independent operators.

I do not have a simple answer for situations when there are fewer than five doctors. I did suggest that they look at something like a military service concept and move doctors around, stationing them in different communities for a certain period of time. One or two doctors with a good, solid, nurse practitioner backup could be well-placed.

There is no easy answer for those communities with only a few doctors. We could make it more palatable with electronic backup, but we will never have a good relationship between an isolated community of 1,200 and one doctor. It is just too hard on the doctor, even when the public tries to be understanding. It is hard to be understanding if a new baby is screaming in the middle of the night. It may be nothing, but we do not know that.

Senator Fairbairn: With all the other services that have been chipped away over the years in small communities, it becomes a survival-of-community issue at some point.

Mr. Scott: We could look at industries such as pulp and paper and some mining facilities. They are now looking carefully at whether their marginal operations will continue because they cannot get employees due to the lack of medical services in the area.

Senator Fairbairn: It might be useful, Mr. Chairman, if we could get a copy of the report.

Senator Cohen: I wanted to ask you about the Canada Health Act, if you think that the criteria are still important. Do you believe anything should be added to it, such as sustainability? I would like your personal opinion on the act as it stands today in view of what is happening across the country.

Mr. Scott: My last experience was in the negotiations leading up to the Canada Health Act. They were quite colourful. I was looking through Monique Bégin's testimony to see what she had said.

I do not have a problem with the Canada Health Act. I have a problem with the environment that has been created around it and a problem with the act being used as a blunt instrument by the federal government to make themselves champions of health care. That is my only complaint about the act.

M. Scott: Oui. Dans une localité dotée d'un hôpital, on ne peut pas s'attendre à assurer la stabilité des services de médecin s'il y a moins de cinq médecins. C'est aléatoire avec cinq ou six médecins. Toutefois, si toutes les bonnes conditions sont réunies, si la localité est compréhensive et si on a davantage recours aux infirmières de première ligne et à d'autres soignants, il est peut-être alors possible d'assurer une stabilité dans cette localité. C'est impossible s'il y a moins de cinq médecins.

Les jeunes médecins les plus énergiques sont épuisés au bout de deux ou trois années. Ceux qui ont de l'endurance ont tendance à repousser les nouveaux médecins, car ils ont également tendance à être indépendants et dominants.

Je n'ai pas de réponse simple à apporter dans les cas où il y a moins de cinq médecins. J'ai proposé un concept se rapprochant de celui du service militaire qui permet de déplacer les médecins, de les affecter dans diverses localités pendant un certain temps. Un ou deux médecins avec une infirmière de première ligne solide, ce serait la solution.

Il n'y a pas de réponse facile pour les localités qui n'ont qu'un nombre restreint de médecins. On pourrait rendre la situation plus intéressante en prévoyant un appui électronique, mais il ne sera jamais possible d'instaurer de bons rapports entre une localité isolée de 1 200 habitants et un médecin. La charge est tout simplement trop lourde pour le médecin, même si le public essaie d'être compréhensif. Il est difficile d'être compréhensif lorsqu'un nouveau-né hurle au milieu de la nuit. Ce n'est peut-être rien de grave, mais on ne le sait pas.

Le sénateur Fairbairn: Vu l'élimination progressive au fil des ans de tous les autres services dans les petites localités, cela finit par poser une question de survie.

M. Scott: Nous pourrions examiner le cas d'industries comme celles des pâtes et papiers et de certaines installations minières. Elles se demandent maintenant si leurs opérations marginales vont pouvoir se poursuivre parce qu'elles ne peuvent pas recruter des employés à cause du manque de services médicaux dans la région.

Le sénateur Fairbairn: Il serait utile, monsieur le président, d'avoir une copie du rapport.

Le sénateur Cohen: Je voulais vous demander, si, d'après vous, les critères de la Loi canadienne sur la santé sont toujours importants. Pensez-vous qu'il faudrait en ajouter d'autres, comme celui de la rentabilité? J'aimerais avoir votre avis personnel au sujet de la loi telle qu'elle est libellée aujourd'hui, compte tenu de ce qui se passe dans l'ensemble du pays.

M. Scott: Ma dernière expérience remonte aux négociations qui ont abouti à la Loi canadienne sur la santé. Elles étaient très animées et j'ai relu le témoignage de Monique Bégin pour voir ce qu'elle avait dit.

La Loi canadienne sur la santé ne me pose aucun problème. Par contre, j'ai du mal à accepter l'environnement qui a été créé et le fait que le gouvernement fédéral se serve carrément de la loi pour se déclarer le champion des soins de santé. C'est tout ce dont j'ai à me plaindre au sujet de la loi.

I agree with earlier testimony that the act is an icon and should be left alone. My view is that we do not need to change the Canada Health Act to fix things up.

I constantly hear that the open-ended nature of medical services should be defined. I cannot think of a more destructive exercise. The principles are fine.

The public administration provisions allow one to use the private sector if that may be constructive, provided that the responsibility remains with the public. My only reservation would have been if the act had said that only the government could be involved in day-to-day administration. I would have said that that was wrong. That is not my interpretation of the act, so I am comfortable with it.

Senator Robertson: Mr. Scott, we have had a lot of frustration at this table since we started this exercise with the system. There is an anxiousness to improve, but we seem to run into walls all the time. Suppose that you had a clean slate and that we did not have medicare, but you did have the knowledge that you have now. What would be five or six component parts if you were to redesign the system, without worry about all the political ramifications and the professional commotion? What would you start with?

Mr. Scott: I would start with an integrated system. These artificial distinctions between home care and hospitals are ridiculous. We have them and we have them in spades. I think that is the first place I would start.

I would say that the whole system is a continuum, a patient-based continuum. We would not have the situation we have now with hospitals putting people into home care but hiring all of the nurses out of home care. We should not have those kinds of contradictions. We would need an integrated system.

I would also look at the relationship between the primary provider groups. Nurses deserve and ought to have more status in accordance with their qualifications. They should be seen as parts of teams rather than as adjuncts or add-ons to teams.

Notwithstanding all that I have said about alternative payment plans, I would not require all physicians to be in an alternate payment plan. There is probably room for some reformed fee for service, but not at the primary level. I am totally opposed to it at the primary level. I do not think it could work meaningfully in most cases. There may be cases where I am wrong, but I am prepared to be flexible.

Doctors, like everyone else, are driven by different incentives. There are brilliant doctors who work long hours and do not earn much because they prefer the academic environment. There are doctors who like to be paid a lot and lawyers who like to be paid a lot. There must be flexibility. No one system fits all.

Je suis d'accord avec ce qui a été dit plus tôt, la loi est un emblème et il ne faudrait pas y toucher. À mon avis, ce n'est pas en modifiant la Loi canadienne sur la santé que l'on va arranger les choses.

Je ne cesse d'entendre dire que la nature non limitative des services médicaux devrait être définie. Je ne peux pas imaginer d'exercice plus destructif. Les principes ne posent aucun problème.

Les dispositions relatives à l'application de la loi par le secteur public permettent d'avoir recours au secteur privé en cas de nécessité, dans la mesure où la responsabilité reste du domaine public. La seule réserve que je pourrais avoir c'est si la loi avait stipulé que seul le gouvernement pouvait s'occuper de l'application quotidienne de la loi. J'aurais dit que cela n'était pas bon. Ce n'est pas mon interprétation de la loi, si bien que je n'ai pas de problème à cet égard.

Le sénateur Robertson: Monsieur Scott, nous ressentons tous ici beaucoup de frustration depuis que nous avons commencé cet exercice. Nous voulons améliorer les choses, mais nous semblons constamment nous heurter à des murs. Imaginez que tout était à faire, que le régime de soins de santé n'existait pas, mais que vous aviez les connaissances que vous avez maintenant. Quels seraient les cinq ou six éléments du régime que vous proposeriez si vous deviez en concevoir un, sans vous soucier des ramifications politiques et professionnels? Par où commenceriez-vous?

M. Scott: Je commencerais par proposer un régime intégré. Les distinctions artificielles entre les soins à domicile et dans les hôpitaux sont ridicules; nous en avons en grand nombre. Je crois que ce serait mon point de départ.

Je dirais que tout le régime est un continuum, basé sur les patients. On ne se retrouverait pas dans la situation actuelle où les hôpitaux renvoient les gens chez eux pour recevoir des soins à domicile tout en embauchant l'ensemble des infirmières dans les hôpitaux. Il ne faudrait pas avoir ce genre de contradictions. On a besoin d'un régime intégré.

J'examinerais également les rapports qui existent entre les groupes de soignants primaires. Les infirmières méritent un meilleur statut en fonction de leurs qualifications. Elles devraient être considérées comme membres de l'équipe, plutôt que comme ajouts.

Nonobstant tout ce que j'ai dit au sujet des modes de paiements alternatifs, je n'exigerais pas que tous les médecins y soient soumis. Il est probablement possible de réformer le régime des honoraires à l'acte, mais pas au niveau primaire. J'y suis complètement opposé dans ce cas précis. Je ne pense pas que cela fonctionnerait bien dans la plupart des cas; il se peut que j'ai tort, dans certains cas, mais je suis prêt à faire preuve de souplesse.

Les médecins, comme n'importe qui, sont sensibles à divers incitatifs. Il y a des médecins brillants qui travaillent de longues heures et qui ne gagnent pas trop d'argent, car ils préfèrent le milieu universitaire. Il y a des médecins qui aiment être très bien payés, tout comme des avocats. Il faut qu'il y ait de la souplesse, car aucun système ne convient à tous.

Some interesting studies were done 10 years ago in the United States, and I think that they still stand. We cannot fit all physicians into one box and expect the system to work.

Although not many people thought of it, instituting fee for service put physicians in a box. Most of the doctors I talk to would like to get out of fee for service. They cannot get out of fee for service as they have the same fear that each of us has about changing jobs or being demoted or promoted. The physicians have legitimate concerns about change, as do we all, and we must find ways to address that fear.

A key to addressing it would be to get it right the first time. I have a philosophy that anything you have right now will not be right 10 years or 15 years from now.

Senator Robertson: Thank you for that. I think that this committee must look at what is going on with all these things.

I have one more question. It is not meant to be a political question.

You have worked for a variety of governments in one capacity or another and you have political convictions. Some of us get the feeling that you would have the federal government provide an increased ratio of funding. We know that it dropped to 50 per cent from where it is today. It would be easier during negotiations to be on a friendlier basis with the provinces if there were a methodology whereby the federal government could get recognition, no matter the political stripe.

If the federal government provides more money, how does the public know that it is giving money? Does the public really know if the government is contributing a certain percentage? How do we fully recognize the contribution of the federal government? If we could find a nice way of doing that, more money would be available.

Mr. Scott: I do not think I can say much about that. I agree with it, but we must first bear down on the incredible barrier of distrust. I can think of many existing programs in this country where federal and provincial ministers and municipal people get together to cut ribbons and do all sorts of things.

There is no reason this cannot happen in health care. However, it will be slow and it will take the effort of several leaders. I understand the need for credit. I do not have a problem with that. I can see why any federal government would want recognition if it were to pour in money. I suppose that there will be credit in the recent deal because the federal government will be at ribbon-cutting ceremonies for new MRI machines. There should be more of that because it keeps the parties together.

No matter how well intended the federal government is in saying that there are great sums of money earmarked for home care, for example, that resonates very well with the provinces.

Des études intéressantes ont été faites il y a dix ans aux États-Unis et je pense qu'elles sont toujours valables. Il est impossible de faire entrer tous les médecins dans une seule catégorie et de s'attendre à ce que le régime fonctionne.

Contrairement à ce que beaucoup de gens ont cru, l'instauration des honoraires à l'acte a enfermé les médecins dans une catégorie. La plupart des médecins que j'ai rencontrés aimeraient sortir du régime des honoraires à l'acte, mais ils ne peuvent pas le faire, car ils ont la même crainte que chacun de nous pourrait avoir lorsqu'il s'agit de changer d'emploi, d'être rétrogradé ou promu. Les inquiétudes des médecins au sujet du changement sont légitimes, comme c'est le cas de nous tous et il faut trouver des moyens d'atténuer cette crainte.

La solution consisterait bien sûr à y arriver du premier coup. Selon ma philosophie, tout ce qui fonctionne aujourd'hui ne fonctionnera plus dans 10 ou 15 ans.

Le sénateur Robertson: Merci. Je crois que le comité doit examiner l'évolution de la situation.

J'ai une autre question qui ne se veut pas politique.

Vous avez travaillé pour divers gouvernements et vous y avez rempli plusieurs fonctions; par ailleurs, vous avez des convictions politiques. Certains d'entre nous ont l'impression que vous souhaiteriez que le gouvernement fédéral augmente le pourcentage du financement. Nous savons qu'il a été ramené à 50 p. 100 comparé à ce qu'il est aujourd'hui. Les négociations avec les provinces seraient plus amicales s'il existait un moyen pour le gouvernement fédéral d'être reconnu, indépendamment de l'allégeance politique.

Si le gouvernement fédéral donne plus d'argent, comment le public peut-il le savoir? Le public sait-il véritablement si le gouvernement contribue un certain pourcentage? Comment reconnaître pleinement la contribution du gouvernement fédéral? Si nous pouvions trouver une bonne façon de le faire, plus de fonds seraient disponibles.

M. Scott: Je ne pense pas pouvoir en dire beaucoup à ce sujet. Je suis d'accord, mais il faut d'abord abattre l'incroyable obstacle que représente la méfiance. Il existe beaucoup de programmes dans notre pays où les ministres fédéraux et provinciaux ainsi que les représentants des municipalités se réunissent pour couper un ruban et faire ce genre de choses.

Je ne vois pas pourquoi cela ne pourrait pas se faire dans le domaine des soins de santé. Toutefois, cela va prendre du temps et nécessiter des efforts de la part de plusieurs leaders. Je comprends la nécessité de reconnaissance et cela ne me pose aucun problème. Je peux voir pourquoi un gouvernement fédéral souhaiterait être reconnu s'il injecte des fonds; j'imagine que cette reconnaissance sera prévue dans le cadre de l'entente récente, car le gouvernement fédéral participera à des cérémonies d'inauguration de nouvelles machines IRM. Il faudrait multiplier les occasions de cette nature car cela permet de conserver l'unité des parties.

Peu importe les bonnes intentions du gouvernement fédéral; lorsqu'il déclare que d'énormes sommes d'argent sont prévues pour les soins à domicile, par exemple, les provinces y sont fort

Each province is at a different level in regard to home care. They see a home care program that might be different.

I do not mean to jump to conclusions. This is a natural environment that occurs.

A province may say that it does not need money for home care but rather for emergency wards. That escalates the environment into maximum negative. We have seen that. I think that there is no fault entirely on any one side. However, unfortunately it is the tradition, and it will take leadership to break through that tradition. Perhaps the answer lies in the suggestion that Tom Kent made about entering into a permanent commitment, in exchange for which the provinces get the guarantee that they will be protected within certain parameters, in exchange for which the federal government is given a more active area for which it can take credit.

Senator Robertson: It would be very expensive, but perhaps each family should receive a statement of the health benefits they accrue during the year. The statement could indicate that 50 per cent of the cost is borne by the province and 50 per cent by the federal government.

The Chairman: One of the interesting things I found in reading the paper you sent us before you testified today is how well incentives have worked with physicians. You noted that if a particular behaviour pattern is desired, give them the fee schedule and they will figure out how to maximize their self-interest with respect to the fee schedule. I do not say that negatively. That is exactly what human beings ought to do.

I found that rather encouraging. I am thinking of your suggestion that more family practitioners ought to have their offices open in the evening and that they be paid differently if they see someone after five o'clock. If we were to do that, we would find a lot of practitioners open in the evening.

You talked about incentives in the context of physicians. The medical system consists of both patients and physicians. Has anyone looked at the various ways of putting incentives, or disincentives, into the patient side of the system to encourage a different form of behaviour by patients?

I happen to have had some experience in emergency wards in the past several weeks. To be blunt, I am amazed at the number of people in emergency wards who ought not to not be there. The result is that a number of people who clearly need to be treated more quickly do not receive treatment quickly because there is a backlog. I am not sure that I would agree with the person on the trauma unit who ranks them. I am not criticizing that person.

Surely we need to put more obligations on patients to use the system efficiently, as well as placing that responsibility on physicians. As physicians respond well to incentives, perhaps patients would as well because that is a human reaction. Has anyone looked at the various ways of doing that in Canada or anywhere else?

sensibles. Chacune d'elle a un point de vue différent à propos des soins à domicile et peut envisager un programme particulier à ce sujet.

Je ne veux pas sauter à des conclusions, car c'est un milieu naturel qui évolue.

Il se peut qu'une province dise qu'elle n'a pas besoin d'argent pour les soins à domicile, mais plutôt pour les services d'urgence. Cela intensifie le côté négatif, comme nous en avons déjà été témoins et je ne crois pas que l'on puisse blâmer telle ou telle partie à ce sujet. C'est malheureusement la tradition et il faudra faire preuve de leadership pour y mettre un terme. Peut-être la réponse se trouve-t-elle dans la proposition de Tom Kent à propos d'un engagement permanent, en échange duquel les provinces obtiennent la garantie qu'elles seront protégées dans le cadre de certains paramètres, en échange de quoi, le gouvernement fédéral peut être plus activement reconnu.

Le sénateur Robertson: Ce serait peut-être très coûteux, mais il serait peut-être bon que chaque famille reçoive un relevé des prestations de santé qu'elle acquiert au cours de l'année. Ce relevé pourrait indiquer que 50 p. 100 du coût est supporté par la province et 50 p. 100, par le gouvernement fédéral.

Le président: Un des points intéressants que j'ai découverts en lisant le document que vous nous avez envoyé avant votre témoignage d'aujourd'hui, ce sont les incitatifs et le bon accueil que leur réservent les médecins. Vous avez souligné que si un comportement particulier souhaité, il suffit de leur donner le barème des honoraires pour qu'ils comprennent comment maximiser leurs intérêts par rapport au barème. Je ne le dis pas de façon négative. C'est dans la nature humaine.

Cela me paraît assez encourageant. Je pense à votre proposition: il faudrait que plus de médecins de famille travaillent le soir et qu'ils soient payés différemment s'ils voient un patient après cinq heures. Si on le faisait, beaucoup de cabinets seraient ouverts le soir.

Vous avez parlé des incitatifs dans le contexte des médecins, or le système médical se compose des patients et des médecins. Dans le cas des patients, a-t-on examiné la possibilité de proposer divers incitatifs ou de prévoir des moyens de dissuasion afin d'encourager les patients à avoir un comportement différent?

Ces dernières semaines, j'ai dû aller aux urgences. Pour être franc, je suis étonné par le nombre de personnes dans le service des urgences qui ne devraient pas y être. Il s'ensuit que plusieurs personnes qui, de toute évidence doivent être soignées plus rapidement, ne bénéficient pas d'un traitement rapide parce qu'il y a trop de monde. Je ne suis pas sûr d'être d'accord avec la personne de l'unité de traumatologie qui décide des priorités, sans pour autant la critiquer.

Il faut certainement imposer plus d'obligations aux patients pour qu'ils utilisent le système efficacement, ainsi que demander aux médecins d'être responsables de cette efficacité. Comme les médecins réagissent bien aux incitatifs, peut-être qu'il en serait de même pour les patients, puisque c'est une réaction humaine. A-t-on envisagé les diverses façons de le faire au Canada ou ailleurs?

Senator Banks: In Alberta, it is user fees.

The Chairman: That is one model. Tom Kent proposed a different one that was interesting. He proposed that at the end of the year an individual would get a T4 slip equal to the value of health care services they had consumed in that year, up to a fixed amount. I believe that he mentioned \$5,000.

I do not know how good an incentive that would be. It is a means test after the fact. The poor would not pay because they do not pay income tax. The user-fee model is a before-use disincentive system.

Surely, someone in this world must be looking at how to get patients to respond or use the system better than they are using the system currently.

Mr. Scott: I am not an expert on that. By and large, I would say that efforts have been placed on disincentives. Some studies indicate that people would adjust with some training so that they would be comfortable with a nurse practitioner. They will not so readily say that they are not being well served unless seeing a doctor. We still do not have that type of system in place to properly help people to develop this broader confidence or a better sense of where they could go to be treated in the system.

There is some work out there, but I am not an expert on it. There are reports saying that some of this work can be pushed down, but it must be done in an educated manner so people can be confident.

The Chairman: It is not an avenue that you would say is a dead-end street.

Mr. Scott: No.

Senator Kennedy: There is the issue of people going to emergency wards because they do not have any other place to go. They do not have family doctors.

On the home care issue, I want to mention one experience I have had that shows how valuable that service can be. My sister was at my house recovering from heart surgery when she had a stroke and wound up back in the hospital. She was there for a week. When she returned to us, a speech therapist, a physiotherapist and an occupational therapist came once a week. That service was invaluable. My sister was lucky that she could come to our family because care was there. However, other care was provided that would have normally been provided in a hospital. She was with us for three months. One could not put a dollar value on that home care because it was invaluable. How does one teach someone to speak again and to use their hands again? They were absolutely super, and we did not know that this service existed until it was there when we needed it.

Mr. Scott: Home care is not balanced. In some cases, like your example, it works incredibly well and makes the case for integration. In other cases, it does not work at all. Instead, the poor patient finds himself or herself bounced back and forth between hospital and home care for treatment.

Le sénateur Banks: En Alberta, ce sont les frais d'utilisation.

Le président: C'est un modèle seulement. Tom Kent en a proposé un autre qui est intéressant. Il propose qu'à la fin de l'année, on reçoive un relevé T4 correspondant à la valeur des services de soins de santé utilisés au cours de l'année, jusqu'à concurrence d'un plafond de 5 000 \$, je crois.

Je ne sais pas si cet incitatif serait valable. C'est un examen des moyens après coup. Les pauvres ne paieraient pas, car ils ne paient pas d'impôt sur le revenu. Le modèle des frais d'utilisation est un modèle de dissuasion avant l'utilisation.

Il y a sûrement quelqu'un qui cherche à savoir comment on pourrait faire réagir les patients ou comment on pourrait les inciter à utiliser le système mieux qu'ils ne le font actuellement.

M. Scott: Je ne suis pas spécialiste en la matière. En général, je dirais que les efforts ont été axés sur les moyens de dissuasion. D'après certaines études, les gens finiraient par s'habituer aux infirmières de première ligne si on leur en donnait la possibilité. Ils ne seraient pas autant portés à dire qu'ils ne sont pas bien servis s'ils ne voient pas un médecin. Nous n'avons toujours pas un système qui permette d'aider les gens à avoir plus confiance ou à mieux savoir à qui s'adresser pour recevoir des soins.

Il y a du travail à faire, mais je ne suis pas spécialiste dans ce domaine. D'après certains rapports, les soins peuvent être dispensés par des soignants autres que les médecins, mais cela doit se faire de manière informée pour que les gens puissent avoir confiance.

Le président: D'après vous, ce n'est pas quelque chose d'impossible.

M. Scott: Non.

Le sénateur Kennedy: Si des gens se rendent dans les services des urgences, c'est parce qu'ils ne peuvent aller ailleurs, car ils n'ont pas de médecin de famille.

Pour ce qui est des soins à domicile, j'aimerais vous parler d'une expérience personnelle qui montre jusqu'à quel point ce service peut-être précieux. Ma soeur se trouvait chez moi après une chirurgie cardiaque, lorsqu'elle a eu un accident cérébrovasculaire; elle dû être ramenée à l'hôpital où elle a séjourné une semaine. Lorsqu'elle est revenue chez nous, un orthophoniste, un physiothérapeute et un ergothérapeute sont venus une fois par semaine. Ce service a été des plus précieux. Ma soeur a eu de la chance dans la mesure où nous avons pu la recevoir et où elle a pu recevoir des soins. Toutefois, d'autres soins lui ont été dispensés qui, normalement, auraient dû lui être offerts dans un hôpital. Elle a passé trois mois chez nous. On ne peut absolument pas attribuer de valeur monétaire à ces soins à domicile. Comment réapprendre à quelqu'un à parler et à utiliser ses mains? Ces professionnels étaient extraordinaires et nous ne savions pas que ce service existait avant d'en avoir besoin.

M. Scott: Les soins à domicile ne sont pas bien dosés. Dans certains cas, comme dans l'exemple que vous nous avez donné, tout baigne dans l'huile et cela justifie l'intégration. Dans d'autres cas, rien ne va plus. Le pauvre malade fait la navette entre l'hôpital et la maison pour recevoir des soins.

I should like to end on a positive, personal note because many people are worried about the state of our system. You had a negative observation about your experience, Mr. Chairman.

I was last in Ottawa at the end of May, but I want to be clear that I am not blaming Ottawa for this experience. I felt stomach pains going back on the aircraft. I went to my office and felt progressively worse. I decided to check myself into the emergency ward at a Toronto hospital.

I did have a complaint that it took a bit of time to get me to the triage. From the triage, I was taken in immediately and went through a battery of tests. I had a complex acute appendectomy, complex in the respect that it was not easily identifiable. The operation was completed. I was at home in less than 24 hours, and that is with a major incision. Sometimes the system works extremely well.

I must tell you that although I am a former deputy minister and know the president of the hospital, to this day the president of the hospital does not know that I was there. No one I knew saw me. I came in off the street, and because it was an acute situation, I was handled extremely well by the system.

The Chairman: In that positive note, thank you very much for your testimony today, Mr. Scott.

Honourable senators. I have two items of business before we adjourn. Technically, I need two motions. The first motion is to approve the terms of reference on the Subcommittee on Veteran's Affairs, which requires approval of the committee. It is a paragraph and one-half long. The subcommittee approves it unanimously, I am happy to take the motion. Thank you.

The second matter is that I must give notice to have a motion put through the Senate related to Bill C-6. Bill C-6, you will recall, was the famous privatization bill where we had a modest disagreement with the minister, and, ultimately, he came to understand our point of view. In that discussion we did indicate that we would keep a watching brief on how the negotiations were going between the various parts of the health care system and the government in terms of how the Privacy Act will impact on the health care sector.

I think it would be useful to have an update because of some things that I understand to be occurring. Technically, I cannot do that unless I have a motion referring the matter back to the Senate. If you are in agreement, I would be happy to put a motion today.

Senator Robertson: Was the agreement not that they will back to us?

The Chairman: We agreed that if the issue is not resolved in two years, then the existing act goes into effect.

Senator Robertson: That is right.

J'aimerais terminer sur une note personnelle positive étant donné le grand nombre de gens qui s'inquiètent de l'état de notre système. Vous nous avez fait part d'une expérience négative, monsieur le président.

Je suis venu à Ottawa la dernière fois à la fin de mai, mais je veux que vous compreniez bien que je ne blâme pas Ottawa pour cette expérience. J'ai ressenti des douleurs à l'estomac dans l'avion qui me ramenait à Toronto. Je suis rendu à mon bureau et les choses ont empiré progressivement. J'ai décidé de me rendre au service des urgences d'un hôpital torontois.

J'ai de quoi me plaindre qu'il m'a fallu beaucoup de temps pour passer au triage. Une fois cette étape franchie, j'ai été pris en charge immédiatement et on m'a fait subir une batterie de tests. J'avais une appendicite aiguë complexe. Entendez par là qu'elle n'était pas facile à diagnostiquer. J'ai été opéré. En moins de 24 heures j'étais de retour à la maison et il s'agissait d'une incision majeure. Il arrive parfois que le système soit très bien rodé.

Je dois vous dire que, même si je suis un ancien sous-ministre et que je connais le président de l'hôpital, encore aujourd'hui il ne sait pas que j'y ai été soigné. Personne que je connais ne m'y a vu. Je me suis présenté à l'hôpital et comme mon cas était sérieux, j'ai été extrêmement bien pris en charge par le système.

Le président: Sur cette note positive, je vous remercie beaucoup de votre témoignage, monsieur Scott.

Honorables sénateurs, j'ai deux points que nous devons régler avant de lever la séance. La première motion dont j'ai besoin vise à approuver le mandat du Sous-comité des anciens combattants. Il s'agit d'un paragraphe et demi. Le sous-comité l'approuve à l'unanimité et je suis heureux d'accepter la motion. Je vous remercie.

Quant au deuxième point, il s'agit d'un avis de motion. Nous devons faire adopter au Sénat une motion touchant le projet de loi C-6. Le projet de loi C-6, vous vous souviendrez, est le célèbre projet de loi sur la privatisation au sujet duquel nous avons eu un léger désaccord avec le ministre qui s'est finalement rendu à notre point de vue. Dans le cadre de cette discussion, nous avons dit que nous allions continuer d'observer le déroulement des négociations entre les divers intervenants du régime de soins de santé et le gouvernement en ce qui a trait aux répercussions de la Loi sur la protection des renseignements personnels sur le secteur des soins de santé.

J'estime qu'il serait utile qu'on nous fasse rapport sur l'état de la question étant donné certaines des choses qui, je crois comprendre, se passent. Techniquement, je ne peux le faire sans une motion de renvoi de la question au Sénat. Si vous êtes d'accord, je serais heureux de présenter une motion aujourd'hui.

Le sénateur Robertson: L'entente n'était-elle pas qu'ils nous recontacteront à ce sujet?

Le président: Nous sommes convenus que si la question n'est pas réglée dans deux ans, la loi actuelle entre en vigueur.

Le sénateur Robertson: C'est exact.

The Chairman: We said that we would be prepared to help in the negotiations if they got bogged down. Other Senate committees have done that. My sense is that this issue is getting a little bogged down because it is not totally clear to me that all parts of the bureaucracy and the industry are of one accord as to what needs to be done. I think that some modest leverage might be helpful, but I cannot get the committee do this until it is approved.

Senator Robertson: Approved.

The Chairman: Thank you very much.

On Monday, you will receive from the clerk the draft report on phase one of these hearings. I caution you to please watch the confidentiality of the report. We do not need the problems that some other committees have had with respect to leaked documents.

The committee adjourned.

Le président: Nous avons dit que nous serions disposés à prêter main-forte dans les négociations si elles s'enlisaient. D'autres comités du Sénat ont agi de la sorte. J'ai le sentiment que cette question s'embourbe un peu parce que je ne suis pas tout à fait certain que toutes les composantes de la bureaucratie et de l'industrie s'entendent sur ce qui doit être fait. Je pense qu'une légère influence pourrait être exercée mais, sans l'approbation du Sénat, je ne peux amener le comité à le faire.

Le sénateur Robertson: Approuvé.

Le président: Merci beaucoup.

Lundi, la greffière vous transmettra l'ébauche d'un rapport sur la première étape de ces audiences. Veuillez, s'il vous plaît, respecter la confidentialité du rapport. Nous pouvons nous passer des problèmes qu'ont éprouvés certains autres comités en ce qui a trait à des documents qui ont fait l'objet de fuites.

La séance est levée.



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WITNESS—TÉMOIN

As an individual:

Graham Scott, Former Deputy Minister of Health, Province of
Ontario.

À titre individuel:

Graham Scott, ancien sous-ministre de la santé, province de
l'Ontario.

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Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

*Proceedings of the Standing
Senate Committee on*

*Délibérations du Comité
sénatorial permanent des*

Social Affairs, Science and Technology

Affaires sociales, des sciences et de la technologie

Chairman:
The Honourable MICHAEL KIRBY

Président:
L'honorable MICHAEL KIRBY

Thursday, October 5, 2000

Le jeudi 5 octobre 2000

Issue No. 21

Fascicule n° 21

First meeting on:
Bill S-27, An Act to guarantee the
human right to privacy

Première réunion concernant:
Le projet de loi S-27, Loi visant à garantir le droit
des individus au respect de leur vie privée

WITNESSES:
(See back cover)

TÉMOINS:
(Voir à l'endos)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjory LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Fairbairn, P.C.
Beaudoin	Kennedy
* Boudreau, P.C. (or Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Robertson
Cook	

* *Ex Officio Members*

(Quorum 4)

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-présidente: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Banks	Fairbairn, c.p.
Beaudoin	Kennedy
* Boudreau, c.p. (ou Hays)	Keon
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Robertson
Cook	

* *Membres d'office*

(Quorum 4)

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Tuesday, June 27, 2000:

Resuming debate on the motion of the Honourable Senator Finestone, P.C., seconded by the Honourable Senator Hervieux-Payette, P.C., for the second reading of Bill S-27, An Act to guarantee the human right to privacy.

After debate,

The question being put on the motion, it was adopted.

The bill was then read the second time.

The Honourable Senator Finestone, P.C., moved, seconded by the Honourable Senator Cordy, that the bill be referred to the Standing Senate Committee on Social Affairs, Science and Technology.

The question being put on the motion, it was adopted.

ORDRE DE RENVOI

Extrait des *Journaux du Sénat* du mardi 27 juin 2000:

Reprise du débat sur la motion de l'honorable sénateur Finestone, c.p., appuyée par l'honorable sénateur Hervieux-Payette, c.p., tendant à la deuxième lecture du projet de loi S-27, Loi visant à garantir le droit des individus au respect de leur vie privée.

Après débat,

La motion, mise aux voix, est adoptée.

Le projet de loi est alors lu la deuxième fois.

L'honorable sénateur Finestone, c.p., propose, appuyée par l'honorable sénateur Cordy, que le projet de loi soit renvoyé au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

La motion, mise aux voix, est adoptée.

Le greffier du Sénat,

Paul C. Bélisle

Clerk of the Senate

MINUTES OF PROCEEDINGS

OTTAWA, Thursday, October 5, 2000

(29)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 11:13 a.m., the Deputy Chair, the Honourable Marjory LeBreton, presiding.

Members of the committee present: The Honourable Senators Cohen, Fairbairn, P.C., Kennedy and LeBreton (4).

Other senators present: The Honourable Senators Jane Marie Cordy and Sheila Finestone, P.C. (2).

In attendance: From the Research Branch of the Library of Parliament: Kate Dunkley

Also in attendance: The official reporters of the Senate.

WITNESSES:

The Honourable Sheila Finestone, P.C, Sponsor of the bill;

Eugene Oscapella, Legal Adviser and Specialist in Human Rights.

Pursuant to the Order of Reference adopted by the Senate on Tuesday, June 27, 2000, the committee began its consideration of Bill S-27, An Act to guarantee the human right to privacy.

The Deputy Chair made a statement.

Senator Finestone made a statement and, together with Mr. Oscapella, answered questions.

At 12:04 p.m., the committee adjourned to the call of the Chair.

ATTEST:

PROCÈS-VERBAL

OTTAWA, le jeudi 5 octobre 2000

(29)

[Traduction]

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui, à 11 h 13, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Marjory LeBreton (*vice-présidente*).

Membres du comité présents: Les honorables sénateurs Cohen, Fairbairn, c.p., Kennedy et Lebreton (4).

Autres sénateurs présents: Les honorables sénatrices Jane Marie Cordy et Sheila Finestone, c.p. (2).

Également présente: De la Direction de la recherche parlementaire, de la Bibliothèque du Parlement, Kate Dunkley.

Aussi présents: Les sténographes officiels du Sénat.

TÉMOINS:

L'honorable Sheila Finestone, c.p., parrain du projet de loi;

Eugene Oscapella, conseiller juridique et spécialiste en droits de la personne.

Conformément à l'ordre de renvoi adopté par le Sénat le mardi 27 juin 2000, le comité entreprend son étude du projet de loi S-27, Loi visant à garantir le droit des individus au respect de leur vie privée.

La vice-présidente faite une déclaration.

Le sénateur Finestone fait une déclaration et répond aux questions avec l'aide de M. Oscapella.

À 12 h 04, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

EVIDENCE

OTTAWA, Thursday, October 5, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill S-27, to guarantee the human right to privacy, met this day at 11:13 a.m. to give consideration to the bill.

Senator Marjory LeBreton (*Deputy Chairman*) in the Chair.

[English]

The Deputy Chairman: Honourable senators, we are meeting to discuss Bill S-27, which has been advanced by Senator Finestone. I would ask Senator Finestone to address the committee and speak to the bill.

Hon. Sheila Finestone: Madam Chair, I can tell you it is exciting to be in front of my colleagues in the Senate. It is a first experience for me and I hope I do not make too many mistakes. I am joined by Eugene Oscapella, who is here as a legal adviser and as a specialist in the field of human rights, particularly privacy rights. I am very grateful for his presence, as he will be, I am sure, very helpful to us.

Honourable senators, thank you for giving me the opportunity to discuss with you, through the proposed privacy rights charter, this value of privacy which is at the heart of modern democracy. Protecting privacy is not merely a matter of controlling data in the business world. I would remind honourable senators that they studied Bill C-6, the data bill, but I am talking about privacy as a human right, not privacy as a business right. Bill C-6 goes beyond that. It is an issue of fundamental justice. As Professor Ursula Franklin stated four years ago when speaking in Ottawa, "...all the notions of privacy can trace back their origin and validity primarily to considerations of human rights."

Though merely 12 clauses long, the proposed privacy rights charter is in many ways a much broader and larger document. It is intended to fill a significant gap in providing an umbrella of principles to inform the actions of Parliament and the federally regulated private sector. In a graphic way, the privacy rights charter would be an overall umbrella from which the tenets of the right to personal privacy, the right to live alone, would hang as a tapestry against which you would measure and weigh the needed legislative protections — whether criminal or civil — and other measures that need to be taken. There would always a guideline ahead of you, whether from the Parliament of Canada or the federally regulated private sector. The privacy rights charter reflects countless discussions with privacy experts over many months. It incorporates the views of those who would be affected and those who would be served by this legislation.

TÉMOIGNAGES

OTTAWA, le jeudi 5 octobre 2000

Le Comité permanent des affaires sociales, des sciences et de la technologie, auquel a été renvoyé le projet de loi S-27, Loi visant à garantir le droit des individus au respect de leur vie privée, se réunit à 11 h 13 pour étudier le projet de loi.

Le sénateur Marjory LeBreton (*vice-présidente*) occupe le fauteuil.

[Traduction]

La vice-présidente: Honorables sénateurs, nous nous réunissons pour examiner le projet de loi S-27 que propose le sénateur Finestone. Je demanderais au sénateur de nous parler de son projet de loi.

L'honorable Sheila Finestone: Madame la présidente, je dois dire que c'est excitant de témoigner devant mes collègues du Sénat. C'est la première fois que je le fais et j'espère ne pas commettre trop d'erreurs. Je suis accompagnée d'Eugene Oscapella, conseiller juridique et spécialiste des droits de la personne, surtout en ce qui concerne le respect de la vie privée. Je lui suis très reconnaissante d'être des nôtres puisqu'il pourra certainement nous être très utile.

Honorables sénateurs, je vous remercie de me donner l'occasion de discuter avec vous, dans le cadre de vos délibérations sur ce projet de charte du droit à la vie privée, de l'importance du droit à la vie privée, qui est au coeur même de la démocratie moderne. Si l'on veut protéger la vie privée, on ne peut se contenter uniquement de contrôler les données du monde des affaires. Je rappelle aux honorables sénateurs qu'ils ont étudié le projet de loi C-6, sur l'échange de données, mais que cette mesure-ci porte sur la protection de la vie privée à titre de droit individuel et non pas de droit commercial. Le projet de loi C-6 va plus loin. C'est une question de justice fondamentale. Comme le professeur Ursula Franklin l'avait dit à Ottawa il y a quatre ans: «... toutes les notions relatives à la vie privée sont essentiellement issues de l'examen des droits de la personne et tirent leur valeur de ces droits.»

Le projet de charte du droit à la vie privée ne contient que 12 articles, mais ses conséquences sont très vastes. Il vise à combler une grave lacune dans les principes sur lesquels se fondent l'activité du Parlement et le secteur privé régi par le gouvernement fédéral. La charte du droit à la vie privée serait l'arrière-scène dont dépendrait le principe du droit à la vie privée, du droit à habiter seul, et ainsi de suite dont on pourrait se servir pour évaluer les protections législatives nécessaires, soit au criminel, soit au civil, et les autres mesures qu'on devrait prendre. Il existerait toujours une ligne directrice pour guider soit le Parlement du Canada, soit le secteur privé régi par le gouvernement fédéral. La charte du droit à la vie privée reflète une multitude de discussions avec des experts en la matière qui se sont déroulées pendant de nombreux mois. Elle tient compte des opinions de ceux qui seraient visés et de ceux qui seraient servis par cette mesure.

In my former life as a member of Parliament I was privileged to serve as the chair of the House of Commons Standing Committee on Human Rights and the Status of Disabled Persons. During a 10-month period in 1996-97, that committee conducted an extensive examination of the changing face of privacy right across Canada. A key recommendation of the committee was to enact a declaration of privacy rights, and that is what this is all about. This quasi-constitutional document would apply within federal jurisdiction and would take precedence over ordinary federal legislation. It would serve as a benchmark against which the reasonableness of privacy-infringing principles and practices and the adequacy of legislation and other regulatory measures would be assessed. Committee members also expressed the hope that this privacy charter would lead to the adoption of similar legislation by the provinces and territories. The privacy charter before you is the embodiment of that important recommendation.

Concern for privacy, I need hardly remind you, extends back long before the work of that House of Commons committee. As my colleague the Honourable Senator Noël Kinsella mentioned in the Senate chamber, 14th century England saw the introduction of privacy legislation against eavesdroppers and peeping Toms. We have many eavesdroppers and peeping Toms who are far more sophisticated today with high technology. In fact if you look out the window you can see the "muffs." They can pick up the sound on Parliament Hill. That is how sensitive they really are.

The modern formulation of the concept of privacy emerged in the late 19th century, long before information-hungry computers, long before surveillance cameras, long before genetic testing. In the intervening decades we have seen abuses of privacy at the hands of errant governments. In response to those abuses, international instruments have attempted to strengthen privacy rights. I am speaking of instruments such as the Universal Declaration of Human Rights, which was co-written by a Canadian, John Humphrey — who is from my riding — along with Eleanor Roosevelt.

Senator Cohen: Born in New Brunswick.

Senator Finestone: We have a great affinity for the Declaration of Human Rights. You will find privacy integral to that document, as well as to the International Covenant on Civil and Political Rights.

In Canada there is a long history of calls to establish a right of privacy as a means to cement our democracy. In 1971, almost three decades ago, the Department of Communications and the Department of Justice established a task force on privacy and computers. It is amazing that that happened some 30-odd years ago. The executive committee of the task force included two individuals who have gone on to make substantial marks in Canadian society: Alan Gotlieb and Gerald La Forest. I should say Justice La Forest of New Brunswick.

Quand j'étais députée, j'ai eu le privilège d'être présidente du Comité permanent des droits de la personne et de la condition des personnes handicapées de la Chambre des communes. Pendant une période de 10 mois en 1996 et 1997, ce comité a examiné en profondeur l'évolution du droit à la protection de la vie privée partout au pays. L'une des recommandations de ce comité était d'adopter une déclaration du droit à la vie privée et c'est de là que vient cette mesure. Ce document quasi constitutionnel s'appliquerait au secteur qui relève du gouvernement fédéral et aurait préséance sur les lois fédérales ordinaires. Il servirait d'étalon pour déterminer dans quelle mesure les principes et pratiques qui empiètent sur la vie privée sont raisonnables de même que l'à-propos des lois et autres mesures réglementaires. Les membres du comité avaient aussi exprimé l'espoir que la charte du droit à la vie privée inciterait les provinces et territoires à adopter des lois du même genre. La charte que vous avez sous les yeux est l'aboutissement de cette importante recommandation.

Je n'ai nul besoin de vous rappeler que la protection de la vie privée est une question qui préoccupe le public depuis bien avant que le comité de la Chambre des communes n'aborde la question. Comme mon collègue, l'honorable sénateur Noël Kinsella, l'a déjà dit au Sénat, on avait adopté des lois en Angleterre au XIV^e siècle pour protéger les citoyens contre les oreilles indiscretes et les voyeurs. Les oreilles indiscretes et les voyeurs ont maintenant des méthodes beaucoup plus perfectionnées grâce à la haute technologie. Si vous regardez par la fenêtre, vous pourrez voir les dispositifs d'amortissement. Il est maintenant possible de capter les bruits sur la Colline parlementaire. Cela montre à quel point les dispositifs sont perfectionnés.

La notion moderne de vie privée nous vient de la fin du XIX^e siècle, bien avant l'ère des ordinateurs avides d'information, bien avant les caméras de surveillance, bien avant les contrôles génétiques. Depuis, nous avons assisté à des violations de la vie privée de la part de certains gouvernements. À cause de ces abus, on s'est efforcé de mieux protéger les droits à la vie privée grâce à des instruments internationaux comme la Déclaration universelle des droits de l'homme, rédigée en collaboration par un Canadien, John Humphrey, de ma circonscription, et Eleanor Roosevelt.

Le sénateur Cohen: Né au Nouveau-Brunswick.

Le sénateur Finestone: Nous avons donc des liens très forts avec la Déclaration des droits de l'homme. La vie privée est un principe de base dans ce document et aussi dans le Pacte international relatif aux droits civils et politiques.

Au Canada, on réclame depuis longtemps la création du droit à la vie privée pour consolider notre démocratie. En 1971, il y a près de trois décennies, le ministère des Communications et le ministère de la Justice avaient créé un groupe d'étude pour examiner la vie privée et les ordinateurs. Il est vraiment remarquable que cela date d'une trentaine d'années. Le comité exécutif du groupe d'étude comprenait deux hommes qui ont laissé leur marque sur la société canadienne: Alan Gotlieb et Gerald La Forest, ou le juge du Nouveau-Brunswick, devrais-je dire.

Privacy, the task force acknowledged, was vital, "integral to our very conception of what it is to be human." The prescient report of the task force warned of the enormous technological capabilities of computerized information systems and their ability to raise threats to human values like privacy. The report stated:

Whatever the likelihood, or indeed the value, of finding in natural law, written law, or political theory a basis for a "right to privacy," the important fact is that there seems to be an increasing expectation that such a right should be socially and legally recognized.

The report also mentioned:

...the threat to individuality posed by the very concentration and processing of large quantities of data about individuals. This threat is one of conformist behaviour induced by the certainty that one's file exists and grows, coupled with the uncertainty as to what it contains and the uses to which it will be put.

Those comments were valid three decades ago. They are even of greater urgency today and support an important precept: Simply because we have the technology to intrude into the lives of individuals does not mean that we should intrude. I believe a well-known American stated that not only do we intrude, we also actually commit theft when we intrude in certain measures, such as copying copyright materials and things of that nature. It all falls under what was possible, what is possible and what we should do with what is possible.

The report then cites Professor Alan Westin's warning that public awareness of the potential use of personal information about individuals would lead to more "behaviour for the record" and less freedom of action and expression. People will be concerned, he said, not only with going on the record but also with how that record will look to those in authority. For me, Professor Westin's comments sound a warning bell about the risk of authoritarianism creeping into our lives through our failure to protect our privacy and to respect our democracy.

The task force report made several important suggestions. The one that struck most forcefully was its call for an overall concept of privacy. That overall concept, the report continued, might serve to guide both general statutory enactments by federal and provincial governments establishing a right to privacy in law and particular acts governing the activities of specific institutions or industries.

A privacy right was included in almost the very first draft proposed by the federal government when it unveiled its Charter of Rights and Freedoms. As we all know, an explicit right did not

Le groupe d'étude reconnaissait que la vie privée était essentielle et faisait partie intégrante de la notion même de ce que c'est qu'être humain. Le groupe d'étude avait vu loin et nous avertissait des capacités technologiques énormes des systèmes informatisés et de la menace qu'ils pouvaient représenter pour certaines valeurs comme le droit à la vie privée. Le rapport disait ceci:

Peu importe dans quelle mesure il est probable ou même utile de trouver dans la loi naturelle, dans le droit ou la théorie politique le fondement d'un droit à la vie privée, ce qu'il faut reconnaître, c'est que le public semble s'attendre de plus en plus à ce que ce droit soit reconnu par la société et par la loi.

Le rapport mentionnait aussi:

[...] la menace à l'individualité posée par la concentration même et le traitement de grandes quantités de données sur les particuliers. Il s'agit d'une menace de comportement conformiste suscitée par la certitude que le dossier de chacun existe quelque part et contient de plus en plus de choses associée à l'incertitude quant au contenu exact de ce dossier et à l'utilisation qu'on en fera.

Ces observations étaient justes il y a trois décennies. Elles sont encore plus urgentes aujourd'hui compte tenu d'un principe important: ce n'est pas simplement parce que nous avons les technologies voulues pour nous immiscer dans la vie des particuliers que nous devons le faire. Je pense qu'un Américain bien connu a déclaré qu'il s'agit non seulement d'une intrusion, mais aussi d'un vol quand nous faisons intrusion dans certains domaines, par exemple en copiant des documents assujettis à des droits d'auteur. Tout cela relève de ce qui était possible à l'époque, de ce qui l'est maintenant et de ce que nous devons en faire.

Le rapport cite aussi l'avertissement du professeur Alan Westin disant que si le public était sensibilisé à l'utilisation possible des renseignements personnels, cela inciterait les particuliers à adopter un comportement pour la forme et limiterait la liberté d'action et d'expression. Selon lui, les gens commenceront à s'inquiéter non seulement de ce qui sera noté dans leur dossier, mais aussi de la façon dont ces dossiers seront interprétés par les autorités. Ces commentaires du professeur Westin sonnent l'alarme au sujet du risque que l'autoritarisme ne prenne le dessus si nous ne protégeons pas notre vie privée et ne respectons pas notre démocratie.

Le rapport du groupe d'étude formulait plusieurs suggestions importantes. La plus frappante était celle qui réclamait l'application d'une notion globale de vie privée. D'après le rapport, ce principe global pourrait servir de guide pour la rédaction de lois générales par le gouvernement fédéral et les provinces afin de protéger le droit à la vie privée dans la loi et pour les lois régissant les activités d'institutions ou d'industries particulières.

La toute première ébauche proposée par le gouvernement fédéral pour sa Charte des droits et libertés comprenait un droit à la vie privée. Comme nous le savons tous, ce droit explicite n'est

appear in the final version of the Charter. Still, calls for the inclusion of a constitutional right to privacy continued.

In 1987, the House of Commons' Standing Committee on Justice and Solicitor General reported on its review of the federal Privacy Act in "Open and Shut: Enhancing the Right to Know and the Right to Privacy." The committee concluded that the absence of a common-law and/or Charter-based right to personal privacy was a significant impediment to protecting individual rights. The committee also recommended that, when the time came to consider amendments to the Charter of Rights and Freedoms, serious consideration be given to creating a simple constitutional right to personal privacy.

In 1991, the Privacy Commissioner of Canada appeared before the Special Joint Committee on a Renewed Canada to advocate amending the Charter of Rights to give Canadians clear constitutional privacy protection. However, as we all know, no constitutional privacy amendments resulted. I think we know quite well why we will not reopen the Constitution at this point. Earlier this year, in his final report as Privacy Commissioner, Bruce Phillips recognized that any government would likely be reluctant to reopen the Charter of Rights in the near future. He was enthusiastic about the passage of Bill C-6, calling it a major milestone in the evolution of privacy protection. He cautioned, however, that the battle was not yet over.

Clearly, there has been some movement to protect privacy in this country. I give you as an example Quebec's Charter of Human Rights and Freedoms, which has obtained a sort of quasi-constitutional status in that province. It affords every person in Quebec the right to respect for his or her private life. I believe it is a role model and an example to all of us in the rest of Canada.

The federal Privacy Act and its provincial and territorial counterparts have helped to control the enthusiasm of governments for collecting, using and disclosing personal information about Canadians.

Bill C-6, following the example of Quebec's private sector data legislation, represents a significant advance in the protection of Canadians' personal information held by the private sector. However, Bill C-6 is limited to data protection and, at least initially, it covers only the federally regulated private sector.

Honourable senators, in the briefing book I have prepared for the committee, you will find Chapter 2 of the study that was done in 1996-97, within which you will see a chronology of all the undertakings worldwide in the field of privacy. I draw to your attention in particular the OECD and the European Union where, if one does not have proper privacy legislation that deals with the economic perspective, not necessarily the human rights

pas contenu dans la version définitive de la Charte. Par ailleurs, on a continué à réclamer l'inclusion d'un droit à la vie privée dans la Constitution.

En 1987, le comité permanent de la justice et du solliciteur général de la Chambre des communes a publié un rapport sur son examen de la Loi fédérale sur la protection des renseignements personnels intitulé: «Une question à deux volets: Comment améliorer le droit d'accès à l'information tout en renforçant les mesures de protection des renseignements personnels». Le comité signalait que l'absence d'un droit à la protection des renseignements personnels basé sur la common law ou sur la Charte nuisait considérablement à la protection des droits individuels. Le comité recommandait que, quand viendrait le temps d'examiner des modifications à la Charte des droits et des libertés, on envisage sérieusement de créer un simple droit constitutionnel à la protection de la vie privée.

En 1991, le commissaire à la protection de la vie privée du Canada a témoigné devant le Comité mixte spécial sur le renouvellement du Canada pour préconiser la modification de la Charte des droits afin de protéger clairement la vie privée des Canadiens dans la Constitution. Cependant, comme nous le savons tous, aucune modification n'a été apportée à la Constitution relativement à la vie privée. Je pense que nous comprenons tous pourquoi nous ne rouvrirons pas la Constitution maintenant. Plus tôt cette année, dans son dernier rapport à titre de commissaire à la protection de la vie privée, Bruce Phillips reconnaissait qu'il était fort probable que le gouvernement fédéral hésite à rouvrir la Charte des droits avant un certain temps. Il se disait très heureux de l'adoption du projet de loi C-6 déclarant que c'était un moment historique dans l'évolution de la protection de la vie privée. Il ajoutait cependant que la bataille n'était toujours pas gagnée.

Certains progrès ont été accomplis pour protéger la vie privée au Canada. Il y a par exemple la Charte des droits et libertés de la personne du Québec, qui a acquis un statut quasi constitutionnel dans la province. Il donne à tous les particuliers au Québec le droit au respect de leur vie privée. Selon moi, cette Charte peut servir de modèle et d'exemple au reste du Canada.

La Loi fédérale sur la protection des renseignements personnels et les lois provinciales et territoriales dans ce domaine ont aidé à restreindre la tendance des gouvernements à rassembler, utiliser et divulguer des renseignements personnels sur les Canadiens.

Le projet de loi C-6, suivant l'exemple de la loi du Québec sur les données obtenues par le secteur privé, représente un progrès important pour ce qui est de protéger les renseignements que possède le secteur privé sur les Canadiens. Cependant, le projet de loi C-6 vise uniquement la protection des données et, pour l'instant, du moins, il ne s'applique qu'au secteur privé régi par le gouvernement fédéral.

Honorables sénateurs, dans la documentation que j'ai préparée pour le comité, vous trouverez le chapitre 2 de l'étude menée en 1996-1997, où l'on montre dans l'ordre chronologique toutes les mesures adoptées à l'égard de la protection de la vie privée un peu partout dans le monde. Je vous signale particulièrement les mesures prises par l'OCDE et l'Union européenne qui n'ont peut-être pas de lois de protection de la vie privée comme telles

perspective, then business restraints will be put in place. That is one reason why we had Bill C-6 and why it is an important and good bill. It is one of the hangers, if I might use that word, that you would find in an over-arching piece of umbrella legislation such as this.

Our courts have also stressed the pivotal role of privacy in a democratic society and read public privacy rights into sections 7 and 8 of the Charter of Rights in specific situations. If you read the Supreme Court decisions, you will find these protections often cited on the issue of privacy. However, that constitutional protection remains fragmented and is not comprehensive.

Those measures are simply not enough. They are only pieces of a much larger privacy pie. Accordingly, for many months I have been working with a dedicated group of privacy advisors and legal counsel to develop Bill S-27, an over-arching statement of principles — a privacy umbrella, if you will — that will serve as a template for the protection of privacy in relation to both the public and the private sectors.

Bill S-27 gives Canadians a means to protect themselves from privacy abuses. It serves as a litmus test to allow people to measure intrusive actions by those around them — governments or private sector organizations. The bill thus seeks to ensure that this fundamental value, this instrument for the preservation of democratic rights, is positioned as securely as our parliamentary processes and our current constitutional realities permit. I might note that Mr. Phillips described Bill S-27 as an alternative he could “enthusiastically support” given that Canadians still do not have a broad constitutional right to privacy.

In Vancouver in March at a privacy protection conference I circulated more than 300 copies of my consultation draft of the charter, following which I distributed another 300 copies to the witnesses who had participated in the House of Commons hearings on privacy. The responses have been very strongly supportive.

At the heart of the privacy rights charter, in its preamble, is the recognition of privacy as a basic human right and a fundamental value. I have given you an annotated legislative guide to this charter, which will you find amongst the papers.

In the preamble is a recognition of privacy as a basic human right and a fundamental value. Privacy is a defining difference between an authoritarian state and one built on democratic principles. The preamble reflects Canada's commitment as a signatory to international human rights instruments to honour and promote privacy. It acknowledges privacy as an interest in the public good, one that is essential to the preservation of democracy and the exercise of many of the rights and freedoms guaranteed under Canada's Charter of Rights and Freedoms.

reliées aux droits de la personne, mais qui imposent néanmoins certaines limitations sur le plan économique et commercial. C'est l'une des raisons pour lesquelles nous avons adopté le projet de loi C-6, et c'est certainement un projet de loi important et utile. C'est l'un des éléments clés qu'on retrouverait dans une loi d'application générale comme celle-ci.

Nos tribunaux ont aussi souligné l'importance de la vie privée dans une société démocratique et ont interprété les articles 7 et 8 de la Charte des droits comme assurant certains droits à la vie privée dans des cas précis. Si vous lisez les arrêtés de la Cour suprême, vous constaterez que la Cour cite souvent ces protections quand il est question de vie privée. Notre Constitution offre cependant une protection fragmentaire et non pas complète.

Ces mesures ne suffisent pas. Elles ne sont que des éléments de la protection de la vie privée. J'ai donc consacré bien des mois à travailler de concert avec un groupe de conseillers et d'avocats à la rédaction du projet de loi S-27, qui contient un énoncé général de principes — une espèce de loi cadre si vous voulez — sur la protection de la vie privée qui permettra de protéger la vie privée dans les secteurs public et privé.

Le projet de loi S-27 donne aux Canadiens le moyen de se protéger contre les intrusions dans leur vie privée. Il servira de facteur déterminant pour permettre aux Canadiens de mesurer les actions intrusives de la part des gouvernements ou des organismes du secteur privé. Il vise à garantir que cette valeur fondamentale, cet outil qui nous permet de préserver nos droits démocratiques, sera assise sur la base la plus solide que nous puissions lui donner dans le cadre de nos processus parlementaires et de nos réalités constitutionnelles. J'ajoute que M. Phillips disait que le projet de loi S-27 constituait une solution de rechange qu'il pourrait appuyer avec enthousiasme vu que les Canadiens n'ont toujours pas un droit constitutionnel général à la protection de leur vie privée.

À Vancouver, en mars dernier, j'ai distribué plus de 300 exemplaires de mon ébauche de la charte lors d'une conférence sur la protection de la vie privée et j'en ai ensuite distribué 300 autres exemplaires aux témoins qui avaient participé aux audiences du Comité de la Chambre des communes sur la protection de la vie privée. La réaction a été très positive.

Le préambule de la Charte du droit à la vie privée reconnaît que tout individu a un droit fondamental au respect de sa vie privée et que ce droit constitue une valeur essentielle. Je vous ai remis un guide législatif annoté que vous trouverez dans votre documentation.

Le préambule reconnaît donc que tout individu a un droit fondamental au respect de sa vie privée et que ce droit est une valeur essentielle. La protection de la vie privée est le principe qui permet de faire la distinction entre un État autocratique et un État qui s'appuie sur des principes démocratiques. Le préambule reflète l'engagement du Canada à reconnaître et promouvoir la protection de la vie privée à titre de signataire des conventions internationales sur les droits de la personne. Il reconnaît que le respect de la vie privée constitue un élément du bien commun qui est essentiel à la préservation de la démocratie et à l'exercice de bon nombre des droits et libertés garantis par la Charte canadienne des droits et libertés.

Bill S-27 seeks to give effect to several principles identified in clause 2 of the bill. The first principle is that privacy is essential to an individual's dignity, integrity, autonomy and freedom and to the full and meaningful exercise of human rights and freedoms. The second is that there is a legal right to privacy. The third is that an infringement of the right to privacy must be justifiable in order to be lawful.

Honourable senators will find much of this language is a reflection of the language in the Charter. I am sure it is ringing that bell as I am outlining this.

Clause 9 states that Bill S-27 will apply to all persons and matters coming within the legislative authority of Parliament. Under clause 3 of the bill, every individual has the right to privacy. That right includes, but is not limited to, physical privacy; freedom from surveillance; freedom from monitoring and interception of privacy communications; and freedom from the collection, use and disclosure of personal information without one's permission. Bill S-27, therefore, goes much beyond the regulation and collection of personal information that you would find in Bill C-6. It deals with all forms of privacy infringement.

Clause 4 states that no person shall unjustifiably infringe on another person's privacy. That same clause entitles every individual to claim and enforce that right to privacy. It also permits every individual to refuse to unjustifiably infringe the right of privacy of another individual without reprisal or threat. We all recognize that privacy rights are not absolute. We must find a fair balance. We cannot say that you can have only this or that privacy; there must be a fair balance within the framework of how we live in a democracy. The key is to prevent unjustifiable infringements, things that should not be done because they do not reflect what we have stated in section 2 and section 3 are our rights. The key is balance. Under subclause 5(2), any infringement of an individual's right to privacy would be improper unless that infringement were reasonable and could be demonstrably justified in a free and democratic society.

Subclause 5(3), sometimes known as the *Oakes* test for those who have followed the Supreme Court decision making in this area, sets out a multi-pronged test for determining whether an infringement is justifiable. To be justifiable, the infringement must first be lawful. Second, it must be necessary to achieve an objective that is compelled by the need to respect another individual's human right or another interest in the public good and it must be sufficiently important to warrant infringing the right to privacy. Under the Criminal Code there are police rights, RCMP rights — everyone has rights, as long as they are acknowledged as rights and they are not outside the purview of a democratic society. In the same way, you could say that there are laws and rules that exist around the health sector — what you need to know in the development of good health public policy.

Le projet de loi S-27 vise à donner effet à plusieurs principes énumérés à l'article 2 du projet de loi. Le premier, c'est que le respect de la vie privée est indispensable à la dignité, à l'intégrité, à l'autonomie, au bien-être et à la liberté des individus, ainsi qu'au plein exercice de leurs droits et libertés. Le deuxième, c'est que le droit au respect de la vie privée est reconnu par la loi. Le troisième, c'est qu'une atteinte au droit au respect de la vie privée n'est licite que si elle est justifiable.

Comme le constateront les honorables sénateurs, cela reflète ce que dit déjà la Charte des droits et libertés. Vous l'avez sans doute déjà constaté.

L'article 9 stipule que le projet de loi S-27 s'appliquera aux personnes et matières qui relèvent de l'autorité législative du Parlement. Selon l'article 3 du projet de loi, tout individu a droit au respect de sa vie privée. Ce droit comprend notamment le droit au respect de son intimité physique; le droit d'être libre de toute surveillance; le droit d'être à l'abri du contrôle et de l'interception de ses communications privées; et le droit d'être à l'abri de la collecte, de l'utilisation et de la communication de ses renseignements personnels sans son autorisation. Le projet de loi S-27 va donc beaucoup plus loin que les dispositions du projet de loi C-6 sur la réglementation et la collecte de données personnelles. Il porte sur toutes les formes d'atteintes à la vie privée.

L'article 4 stipule qu'il est interdit de porter atteinte sans justification au droit d'un individu au respect de sa vie privée. Le même article donne à tout individu le droit de revendiquer et de faire valoir son droit au respect de la vie privée et donne aussi le droit à tout individu de refuser de porter atteinte sans justification au droit d'autrui au respect de la vie privée sans crainte de représailles ou de menaces. Nous reconnaissons tous que le droit au respect de la vie privée n'est pas absolu. Il faut établir un juste équilibre. On ne peut pas dire qu'on va limiter le droit à tel ou tel aspect de la vie privée. On doit établir un juste équilibre des droits dans une société démocratique. L'essentiel, c'est d'empêcher les atteintes injustifiables, les activités qui ne sont pas permises parce qu'elles ne reflètent pas les principes énoncés aux articles 2 et 3 du projet de loi. Le plus important, c'est de maintenir cet équilibre. Selon le paragraphe 5(2), une atteinte au droit d'un individu au respect de sa vie privée est justifiable uniquement si elle est raisonnable et si sa justification peut se démontrer dans le cadre d'une société libre et démocratique.

Le paragraphe 5(3), que ceux qui sont au courant de la décision de la Cour suprême dans ce domaine appellent parfois le critère *Oakes*, établit les critères pour déterminer si une atteinte est justifiable ou non. Pour être justifiable, une atteinte doit être licite. Deuxièmement, elle doit être nécessaire à la réalisation d'un objectif qui est dicté par la nécessité de respecter un autre droit de la personne ou un autre élément du bien commun et dont l'importance est suffisante pour justifier une atteinte au droit au respect de la vie privée. Selon le Code criminel, la police et la GRC ont certains droits. Tout le monde a des droits, mais ils doivent être reconnus comme tels et ne doivent pas dépasser le cadre d'une société démocratique. On pourrait dire de la même façon qu'il existe des lois et des règles qui régissent ce qu'on doit savoir dans le domaine de la santé pour élaborer une bonne

Third, it must not be possible to achieve the objective by any other measure that infringes privacy to a lesser extent. Last, but not least, both the importance of the objective and the beneficial effect of the infringement must outweigh the detrimental effect on privacy.

Some might see Bill S-27 as an attempt to stifle certain activities — policing, for example. This bill is not intended to interfere with the police or other bodies that legitimately need to intrude on privacy. The use of certain police powers exercised in accordance with valid legislation would constitute a justifiable infringement on the right to privacy.

Subclause 5(4) makes it clear that an individual's free and fully informed consent to an interference with privacy would not constitute an infringement. In other words, if I said, "Yes, it is okay to use that information," then I have given my full consent. If I have not been asked — which is like a double negative, thank you very much, negative-option marketing — then I am sorry, I did not say yes and you cannot send it to me and you cannot charge me for the item. That is all part of what would be considered my privacy right.

Under clause 6, the Minister of Justice is obliged to review all proposed legislation and regulations to determine whether they comply with the purpose and provisions of the privacy rights charter. The minister must report any inconsistency to Parliament at the first convenient opportunity and must give public notice by publishing the report in the *Canada Gazette*. The minister must also notify the Privacy Commissioner of Canada of any inconsistency or non-compliance at the first convenient opportunity. If the Privacy Commissioner requests, the minister must consult with and receive advice from the commissioner.

Those review and notification obligations should promote a new sensitivity to the application of legislation and regulations, and I believe new respect. They are necessary to preserve this right in the face of the multitude of pressures to diminish or destroy it. It would also ensure greater transparency in the legislative process. That is something we talk about all the time — transparency, openness.

To provide greater certainty, clause 7 authorizes the Governor in Council to codify the infringements of privacy that are permitted by the privacy charter. This is not a notwithstanding clause or an exceptional provision. The only authority would be to codify those infringements that are justifiable under the Charter. The authority does not extend to producing regulations that violate the Charter.

Bill S-27 also enhances the protection of privacy where governments enter into contracts with organizations outside government. Subclause 8(1) states that every person to whom the privacy charter applies must require that any organizations with which he or she enters into a contract or agreement complies with the privacy charter. Thus government would not be able to sidestep its privacy obligations, for example, by contracting out a

politique de santé publique. Troisièmement, une atteinte est justifiable s'il est impossible de réaliser l'objectif par un autre moyen qui porterait atteinte à la vie privée dans une moindre mesure. Enfin, l'importance de l'objectif et les effets bénéfiques de l'atteinte doivent l'emporter sur les effets préjudiciables que celle-ci a sur la vie privée.

Certains pourraient considérer que le projet de loi S-27 vise à réprimer certaines activités, notamment les activités policières. Cette mesure ne vise pourtant pas à faire obstacle aux organes policiers ou autres qui ont des raisons légitimes de porter atteinte à la vie privée. L'utilisation de certains pouvoirs policiers exercés selon des lois valables constituerait une atteinte justifiable au droit à la vie privée.

Le paragraphe 5(4) stipule aussi qu'une entrave à la vie privée faite avec le consentement libre et éclairé de l'individu ne porterait pas atteinte à son droit au respect de la vie privée. Autrement dit, je peux donner mon consentement en disant: «C'est très bien, vous pouvez utiliser ces renseignements». Si l'on ne m'a pas posé la question, ce qui serait comme les abonnements par défaut, où l'on peut dire: «Je n'ai pas dit oui et vous ne pouvez pas me faire payer pour cela», alors je n'ai pas donné mon consentement. Tout cela fait partie de mon droit au respect de la vie privée.

Selon l'article 6, le ministre de la Justice doit examiner tous les projets de loi et règlements pour voir s'ils sont conformes avec les fins et dispositions de la Charte du droit à la vie privée. Le ministre doit signaler toute incompatibilité au Parlement dans les meilleurs délais possibles et publier un rapport à cet effet dans la *Gazette du Canada*. Le ministre doit aussi aviser le commissaire à la protection de la vie privée de toute incompatibilité dans les meilleurs délais possibles. À la demande de celui-ci, le ministre doit le consulter et recevoir ses conseils.

Ces obligations d'examen et d'avis devraient promouvoir une sensibilisation à l'application de la loi et des règlements et plus de respect selon moi. Ces mesures sont nécessaires pour protéger le droit au respect de la vie privée vu les nombreuses pressions visant à le diminuer ou à le détruire. Cela garantirait aussi plus de transparence dans le processus législatif. La transparence est une chose dont nous parlons constamment.

Pour plus de certitude, l'article 7 autorise le gouverneur en conseil à répertorier des pratiques qui constituent des atteintes justifiables aux termes de la Charte du droit à la vie privée. Ce n'est pas une clause dérogatoire ou d'exception. Seules les atteintes justifiables seraient répertoriées. Le gouverneur en conseil ne pourrait pas établir des règlements qui violent la Charte.

Le projet de loi S-27 augmente aussi la protection de la vie privée lorsque le gouvernement conclut un contrat avec des organismes de l'extérieur. Selon le paragraphe 8(1), quiconque est visé par la Charte du droit à la vie privée doit exiger que les organismes avec lesquels il conclut un contrat ou une entente se conforment aux dispositions de la Charte. Le gouvernement ne pourrait donc pas laisser de côté son obligation de respecter la vie

particular function to an association, corporation, partnership, trade union or Crown corporation.

It is also important that the privacy rights charter have paramouncy over ordinary legislation, since an inconsistency or conflict might arise between the charter and another act. Clause 11 addresses that, so it should be quite clear and there should not be this need to worry about conflict of language. The charter will prevail to the extent of the inconsistency or conflict unless the other act expressly declares that it operates despite the charter. Furthermore, no provision of any other act would be construed so as to derogate from any provision of the privacy charter.

Clause 12 states that the paramouncy provision comes into force only one year after the charter receives Royal Assent. You may find that not long enough, and you may wish to challenge that or change that. That will give Parliament time to amend legislation that might be affected by the paramouncy provision.

Honourable senators, as I stated during the second reading debate on Bill S-27 in the chamber, the bill may not be perfect. We have benefited at various stages from the capable advice of a legislative drafter and from the ideas of individuals who are very experienced with privacy issues. I am most grateful to have Mr. Oscapella, one of those individuals, with me.

Still, its language is necessarily complex. Our full and open review of the bill is clearly in order. I am deeply thankful for the opportunity to start that review in this committee, which has had the benefit of its earlier experience with Bill C-6. We do not want to foster a society where there is no place to hide, where there is no place to be anonymous, where there is no place to express the individuality that we cherish in a democracy. We do not want to be constantly checking over our shoulders to see who is monitoring us. We have seen that type of oppressive behaviour too many times in too many countries. Those are not models of behaviour that Canada wishes to follow.

I do not want to sit idly by watching one of the fundamental pillars of a democratic society vanish through atrophy; nor, I am certain, do you. This must be our commitment to ensure that privacy does not get lost amidst the technological wizardry that is being embraced by surveillance-happy businesses and governments. I know that honourable senators want to provide a legacy of strong democratic institutions and principles for this country that we all love so much. I hope that this privacy rights charter will take us one step closer to ensuring that legacy.

The Deputy Chairman: In listening to Senator Finestone's excellent presentation, I note that she made a reference on page 8 and then in her closing about the fact that we do not wish to foster a society with no place to hide. In your research and consultation, what is your sense of the level of knowledge of ordinary Canadians? Do they realize the extent to which they are being monitored?

Perhaps Mr. Oscapella could answer this. Are Canadians really aware that they are probably being watched more, and listened to, without their consent? I think particularly of surveillance cameras

privée en consentant un contrat pour une activité donnée à une association, société de personnes, organisation syndicale ou société d'État.

Il importe aussi de prévoir que la Charte du droit à la vie privée l'emporte sur les lois ordinaires puisqu'il pourrait y avoir incompatibilité avec d'autres lois. L'article 11 le précise pour bien dire que cela ne causera pas de problèmes. La Charte l'emportera sur les dispositions incompatibles ou contraires à moins que l'autre loi déclare expressément qu'elle a effet indépendamment des dispositions de la Charte. Qui plus est, aucune disposition d'une autre loi ne peut être interprétée de manière à déroger aux dispositions de la Charte.

L'article 12 déclare que la disposition de suprématie entrera en vigueur seulement un an après la date de la sanction royale. Vous jugerez peut-être que ce n'est pas suffisant et vous voudrez peut-être changer cette disposition. Cela donnera au Parlement le temps de modifier les lois qui pourraient être touchées par l'article de suprématie.

Honorables sénateurs, comme je l'ai dit pendant le débat de deuxième lecture du projet de loi S-27 au Sénat, cette mesure n'est peut-être pas parfaite. Nous avons pu profiter des conseils du rédacteur législatif et des idées d'experts en la matière. Je suis très reconnaissante à M. Oscapella, l'un de ces experts, de m'avoir accompagnée aujourd'hui.

Le libellé du projet de loi est nécessairement complexe. Il est donc tout à fait de mise d'en faire un examen complet et public. Je suis profondément reconnaissante au comité d'entamer cet examen vu qu'il a déjà fait l'étude du projet de loi C-6. Nous ne voulons pas créer une société où nous ne pourrions pas nous cacher, où nous ne pourrions pas rester anonymes, où nous ne pourrions pas exprimer notre individualité dans le cadre d'une société démocratique. Nous ne voulons pas regarder toujours derrière nous pour voir qui nous surveille. Nous avons vu ce comportement oppressif trop souvent dans trop de pays. Ce ne sont pas des comportements que le Canada voudrait adopter.

Je ne veux pas rester les bras croisés pendant que l'un des piliers fondamentaux d'une société démocratique disparaît ou s'atrophie et je suis certaine que vous ne voudriez pas le faire non plus. Nous devons nous engager à garantir que le respect de la vie privée ne se laisse pas engloutir par les miracles technologiques qu'utilisent volontiers les entreprises et les gouvernements entichés de surveillance. Je sais que les honorables sénateurs veulent doter le pays que nous aimons tous tellement d'institutions et de principes démocratiques solides. J'espère que la Charte du droit à la vie privée contribuera à cet héritage.

La vice-présidente: En écoutant l'excellent discours du sénateur Finestone, j'ai noté qu'elle parlait à la page 8 et ensuite dans sa conclusion du fait que nous ne voulons pas d'une société où nous ne pourrions pas nous cacher. D'après les recherches et les consultations que vous avez menées, dans quelle mesure les Canadiens ordinaires se sentent-ils surveillés? Se rendent-ils compte de la surveillance exercée à leur endroit?

M. Oscapella pourra peut-être répondre. Les Canadiens savent-ils vraiment qu'on les surveille probablement plus qu'auparavant et sans leur consentement? Je pense surtout aux

in stores. Are people giving consent just because they walk through the door of a store? I often get the sense that Canadians are not as concerned about this as they should be.

Mr. Eugene Oscapella, Legal Adviser and Specialist in Human Rights: Madam Chair, there certainly is an awareness of the need to protect privacy. I do not know how well defined the research has been on the extent to which Canadians are actually aware of the numbers of privacy invasions that are occurring, but a survey done in 1992 did show a substantial level of concern about privacy. The potential for the loss of their privacy was one of the issues of greatest concern to Canadians. A survey done last year reached similar findings, I believe. There is a great deal of concern about the potential for the loss of privacy. People notice it most dramatically in the workplace. There is increasing pressure in Canada to submit to drug testing, which has not been shown to do anything of value for society; nonetheless, there is much pressure. Most of that seems to be coming from the model we see in the United States, where the vast majority of Fortune 500 companies conduct drug testing. People in Canada are now beginning to feel some of those privacy intrusions in a very real way.

Senator Finestone: Yes, with surveillance cameras.

Mr. Oscapella: There are surveillance cameras, as Senator Finestone says, and the cameras we see in the street. We look to the United Kingdom as an example. They have hundreds of thousands of surveillance cameras in public places.

The Deputy Chairman: How do they get around it in the law? When a store puts a triangle sticker on its door indicating electronic surveillance, is consent implied when people walk through that door? Is that how they cover it off legally so that they are able to massively survey people?

Mr. Oscapella: It would vary from province to province. British Columbia, Saskatchewan, Newfoundland, Manitoba and Quebec have, perhaps, better developed privacy legislation than some of the other provinces. Essentially, there is no prohibition against video surveillance. If the police conduct video surveillance they must get a warrant beforehand, but if you or I were to conduct it there would be no prohibition. The provinces I just mentioned have what is called a privacy tort. Quebec has something equivalent in its Civil Code. In those cases you might be able to challenge that sort of surveillance in a court, but there is not much to control video surveillance. The legislative prohibition is on the recording of sound. You can have a video camera installed in your store. However, if you surreptitiously record sound you are committing a criminal offence in certain circumstances. We have no protection for video surveillance, which can be equally intrusive.

caméras de surveillance dans les magasins. Les membres du public consentent-ils à cette surveillance simplement parce qu'ils franchissent la porte d'un magasin? J'ai souvent l'impression que les Canadiens ne s'inquiètent pas autant qu'ils le devraient de la situation.

M. Eugene Oscapella, conseiller juridique et spécialiste en droits de la personne: Madame la présidente, les Canadiens savent qu'on doit protéger leur droit au respect de la vie privée. Je ne sais pas dans quelle mesure la recherche a permis de voir si les Canadiens savent combien de fois on fait atteinte à leur vie privée, mais lors d'un sondage mené en 1992, on avait constaté que les Canadiens se préoccupent beaucoup de leur vie privée. La possibilité qu'on porte atteinte à leur vie privée était l'une des choses qui préoccupait le plus les Canadiens à l'époque. Si je ne m'abuse, c'est aussi ce qu'a constaté un sondage mené l'année dernière. Les Canadiens s'inquiètent beaucoup de la possibilité qu'on cesse de respecter leur vie privée. Ils s'en rendent compte le plus souvent au travail. Il y a de plus en plus de pressions au Canada pour que les travailleurs se soumettent à des tests de dépistage des drogues, même si l'on n'a pas prouvé l'utilité de ces tests pour la société. Ces pressions viennent surtout, apparemment, de ce qui se passe aux États-Unis, où la grande majorité des entreprises de la liste Fortune 500 se livrent à de tels tests. Les Canadiens commencent à ressentir de telles intrusions dans leur vie privée.

Le sénateur Finestone: Oui, avec les caméras de surveillance.

M. Oscapella: Il y a les caméras de surveillance, comme le dit le sénateur Finestone, et les caméras dans la rue. Il suffit de voir ce qui se passe au Royaume-Uni, où il y a des centaines de milliers de caméras de surveillance dans les endroits publics.

La vice-présidente: Comment font-ils pour contourner la loi? S'il y a une étiquette à la porte d'un magasin indiquant la présence de dispositifs de surveillance électronique, ceux qui entrent par cette porte donnent-ils implicitement leur consentement à la surveillance? Est-ce ainsi qu'on respecte la loi tout en prenant des mesures pour surveiller les gens?

M. Oscapella: Cela varie d'une province à l'autre. La Colombie-Britannique, la Saskatchewan, Terre-Neuve, le Manitoba et le Québec ont peut-être de meilleures lois sur la protection de la vie privée que certaines autres provinces. Essentiellement, la surveillance vidéo n'est pas interdite. La police doit obtenir un mandat pour exercer une surveillance vidéo, mais rien ne vous interdit d'avoir ces dispositifs. Les provinces que je viens de mentionner ont créé un délit civil pour atteinte à la vie privée. Le Québec a quelque chose d'équivalent dans son Code civil. On pourrait toujours contester ce genre de surveillance devant les tribunaux, mais il n'y a pas grand-chose dans les lois pour limiter la surveillance vidéo. La loi interdit l'enregistrement audio. On peut donc faire installer une caméra vidéo dans son magasin. Cependant, si l'on fait un enregistrement audio, on commet une infraction criminelle dans certains cas. Nous n'avons aucune protection contre la surveillance vidéo, qui peut être tout aussi intrusive.

Senator Finestone: We are all very concerned about safety and security. Many of those cameras seem to protect the main streets of the cities from crime, or they are used to identify criminals on the streets. However, they displace where the crime is taking place. It is often around the corner or in a back alley. The new technology is able to do the physiognomy of the face and the body, and the police are then able to scan the crowd and pick out the face that is the criminal element.

Certain things are important in the public good and certain things are offensive to us in the public good. For example, cameras are often installed in public washrooms, supposedly to detect those who are pushing drugs or those who are taking drugs or those who are committing sexual assault. However, do they have the right to intrude on you while you are in the bathroom? Prisons have cameras that stare down on the prisoners 24 hours a day in every aspect of their daily life.

Is there any right to any degree of privacy anywhere? I do not know. That question will need to be discussed under criminal or civil law. It is not something we know the answer to. These are all issues that require deep investigation by the public, but we have no template against which to look at what are the values we are talking about. What is the vision that we have for society? What are the values we put before society, and where does a privacy charter for human rights versus a privacy charter for data collection come into play?

The Deputy Chairman: Where do you draw the line between protection of the public and the individual?

Senator Finestone: That is right.

Senator Fairbairn: Senator Finestone, before asking my questions I want to congratulate you on putting forward this piece of legislation. I know how long you have been working in this area and I know your commitment to finding this kind of protection for individuals. I admire you for it and I want to thank you for being here today and for being an activist within the Senate on this issue.

When I look at this, I think back to a document that was brought forward by a former prime minister many years ago — the Bill of Rights.

Senator Finestone: It was John Diefenbaker.

Senator Fairbairn: Yes. That was followed many years later by the Charter of Rights and Freedoms, which had extra strength as a constitutional document.

Earlier, you referred to the charter that you are proposing as a quasi-constitutional document. Could explain that to me?

Senator Finestone: Thank you for that question and for your opening remarks.

It is quasi-constitutional because there is absolutely no opportunity to open the Canadian Charter to include it therein. Although it is found in international charters in many countries — for example, it is found in the international Charter

Le sénateur Finestone: La sûreté et la sécurité nous préoccupent tous beaucoup. Bon nombre de ces caméras semblent être là pour protéger les grandes rues des villes contre le crime, ou pour identifier les criminels dans les rues. Toutefois, elles ne font qu'entraîner un déplacement de la criminalité. Celle-ci, souvent, se déplace vers la rue d'à côté ou la ruelle. La nouvelle technologie nous permet d'établir les physionomies du visage et du corps, et la police peut ensuite faire un balayage de la foule pour y trouver les criminels.

Certaines choses sont importantes pour le bien commun, d'autres y vont à l'encontre. Ainsi, il arrive souvent qu'on installe des caméras dans les toilettes publiques, sous prétexte de trouver les revendeurs de drogue, les consommateurs de drogue et les agresseurs sexuels. Mais a-t-on le droit de violer votre intimité ainsi? Dans les prisons, il y a des caméras qui filment les détenus 24 heures par jour, peu importe ce qu'ils font.

A-t-on droit à un certain niveau d'intimité quel que soit l'endroit? Je l'ignore. Il faudra débattre de cette question dans le contexte du droit pénal ou civil. Nous n'avons pas encore répondu à cette question. Ce sont là des questions qui nécessiteront une étude plus approfondie de la part du public, mais nous n'avons pas de modèle en fonction duquel nous pourrions examiner ces valeurs dont nous parlons. Quelle vision avons-nous pour notre société? Quelles sont les valeurs de notre société, et où se situerait une charte des droits individuels à la vie privé par opposition à une charte des droits à la vie privée en matière de collecte de données?

La vice-présidente: Où se situe la ligne de démarcation entre la protection du public et la protection de la personne?

Le sénateur Finestone: Précisément.

Le sénateur Fairbairn: Sénateur, avant de passer à mes questions, je tiens à vous féliciter pour avoir déposé ce projet de loi. Je sais que vous travaillez dans ce domaine depuis longtemps, et je sais aussi que vous vous êtes engagée à trouver une façon d'accorder ce genre de protection aux personnes. Vous avez toute mon admiration et je tiens à vous remercier d'être ici aujourd'hui et d'avoir été si active à ce sujet au Sénat.

Ce projet de loi me fait penser à un document qui avait été présenté par un ancien premier ministre, il y a bien des années — la Déclaration des droits.

Le sénateur Finestone: C'était John Diefenbaker.

Le sénateur Fairbairn: Oui. Elle a été suivie bien des années plus tard par la Charte des droits et libertés, qui a encore plus de poids puisque c'est un document constitutionnel.

Un peu plus tôt, vous avez dit que la charte que vous proposez est un document quasi constitutionnel. Pourriez-vous m'expliquer cela?

Le sénateur Finestone: Merci de votre question et de votre préambule.

Ce document est quasi constitutionnel car il serait absolument impossible d'ouvrir la Charte canadienne pour l'y inclure. Bien qu'un tel document se retrouve dans bien des chartes internationales, par exemple, la Charte internationale des Nations

of the United Nations — it was left out of the Canadian Charter. I imagine that must have been due to give and take on some federal-provincial level. Mr. Diefenbaker's Bill of Rights has quasi-constitutional status, too. I believe that this privacy charter could arrive at that state as well because the courts would use it as a reference point. The courts can determine whether what is being brought before them fits the *Oakes* test that we have put in here. That *Oakes* test was developed by the Supreme Court in analyzing the justification for bringing a case before the courts. That is the test the Supreme Court would use. We have used exactly the same test so that there is no incompatibility that would create confusion when you are looking at something that might be considered worthy of consideration as going against or for privacy, as the case may be.

This does not define what we should be doing in the instance of genetic testing. It does not say what we should be doing in terms of controlling this new book of life and the human genome. We do not know what will be happening with that. That would have to be new legislation that would be reflective of privacy rights. You would hang that on your overall umbrella. You cannot have one universal law for human rights. Your human rights must reflect fundamental values and must be tailored to individual cases, if I could put it that way.

I will use something that is dear to the hearts of some of our colleagues, namely, the question of the census. How do we describe that?

Mr. Oscapella: The archives?

Senator Finestone: Yes.

Mr. Oscapella: The issue we were discussing was whether, under this legislation, archiving personal information would be prohibited. It would not, but it would set a standard for the archiving of information.

I wish to return to the point of the quasi-constitutional status. That would flow primarily from the final clauses of the legislation — the non-derogation of the clause and the paramountcy provisions in subclauses 11(1) and 11(2) of the bill. This bill would stand above all other legislation. It would be paramount to all other legislation unless it was declared otherwise. This bill would also apply to laws that existed before this bill came into force. That would give it its overarching umbrella quality, its quasi-constitutional status, in effect. That is how we were looking at structuring this.

Senator Fairbairn: Presumably that would be played out, almost by definition, through actual rulings of courts as these issues were raised in the legal process.

Mr. Oscapella: Very much so. Clause 4 states that every individual is entitled to claim and enforce their right to privacy. We would look at courts as the primary vehicle for developing this overarching set of principles beyond the strict wording of the legislation itself.

Senator Kennedy: I will ask you my question personally at a later date because I do need to leave and I am not anticipating a brief answer, but I do congratulate you on this important work. I

Unies, il a été exclu de la Charte canadienne. J'imagine que c'est attribuable à des compromis qu'on a dû faire dans le cadre des relations fédérales-provinciales. La Déclaration des droits de M. Diefenbaker était aussi un document quasi constitutionnel. Je crois qu'il pourrait en être ainsi de la Charte du droit à la vie privée car les tribunaux pourraient s'en servir comme point de référence. Les tribunaux pourraient déterminer si la cause qui leur est présentée satisfait aux critères de l'arrêt *Oakes* qu'on y trouve. Le critère *Oakes* a été retenu par la Cour suprême pour l'analyse permettant de déterminer si une affaire peut être entendue par les tribunaux. C'est le critère qu'applique la Cour suprême. Nous avons repris précisément le même critère afin qu'il n'y ait pas d'incompatibilité qui créerait la confusion au moment de déterminer si une affaire mérite d'être entendue parce qu'elle soulève des questions d'atteinte à la vie privée.

Cela ne définit pas ce que nous devrions faire dans les cas de tests génétiques. Cela ne nous dit pas ce que nous devrions faire pour contrôler ce nouveau livre de vie et le génome humain. Nous ignorons ce qu'il adviendra de tout ça. Ça devra faire l'objet d'une nouvelle mesure législative qui tiendrait compte du droit à la vie privée. Cela s'inscrirait dans un cadre général. On ne peut prévoir une loi universelle pour tous les droits de la personne. Les droits de la personne doivent refléter les valeurs fondamentales et être adaptés à chaque cas, si je peux m'exprimer ainsi.

Je prends un exemple qui est cher au coeur de certains de nos collègues, soit la question du recensement. Comment décrivons-nous cela?

M. Oscapella: Les archives?

Le sénateur Finestone: Oui.

M. Oscapella: La question était de savoir si, aux termes de ce projet de loi, il serait interdit d'archiver les informations personnelles. Non, mais l'archivage de ces renseignements se ferait selon certaines normes.

J'aimerais revenir à la question de la quasi-constitutionnalité de la Charte du droit à la vie privée. Cela découlerait principalement des dernières dispositions du projet de loi — le paragraphe interdisant la dérogation et celui prévoyant la suprématie de cette loi, les paragraphes 11(1) et 11(2). Ce projet de loi l'emporterait sur toute autre disposition incompatible ou contraire, sauf les déclarations contraires. Il s'appliquerait aussi aux lois existant avant son entrée en vigueur. Cela lui donnerait une application très générale et, dans les faits, en ferait un texte de loi quasi constitutionnel. C'est ce qui nous est apparu la meilleure structure.

Le sénateur Fairbairn: Je présume que cela se concrétiserait, presque par définition, dans les décisions des tribunaux, au fur et à mesure que ces questions seraient soulevées dans les procédures judiciaires.

M. Oscapella: Tout à fait. L'article 4 stipule que tout individu peut revendiquer et faire valoir son droit au respect de la vie privée. Les tribunaux seraient la principale tribune où s'élaborerait l'ensemble de principes allant au-delà du libellé du projet de loi.

Le sénateur Kennedy: Je devrai vous poser ma question plus tard, car je dois partir et je m'attends à ce que votre réponse à ma question ne soit pas brève, mais je tiens à vous féliciter d'avoir

will put my question on the record, though. It is with respect to the encryption of material, particularly in a medical sense. It is not too difficult to see the day when we would all have our medical history in one file, and it should be encrypted. Who will own that? Will the hospital own it, will a doctor own it, or will we own it?

Senator Finestone: I can give you an answer but it would be a personal opinion, and it is an important question. That medical history would be data collection that would fall under Bill C-6. When the health issue comes into effect under Bill C-6, which has been delayed by a year, that question should be answered because it is one of the aspects of personal privacy. It is one of the reasons why we need a privacy charter. I say to you that you should own your medical history yourself, because this is a privacy charter for individuals in Canada. As a Canadian citizen living in a democratic society, I should have the right to control the information about me. I should have the right to say, "Yes, you need to know this," and "No, you do not need to know this." The government has said, under the right to draw regulations, that while certain things will abrogate your privacy, it may determine that the encryption system belongs to the Health Department. I do not know. It is a discussion that needs to take place.

Senator Fairbairn: To what degree have you discussed or worked through this charter with the Minister of Justice, who obviously would be an important player in making it work?

Senator Finestone: I can speak only from personal experience. We wrote our report in 1996 and it was given to the Minister of Justice in the House of Commons. The House broke for an election, and we had no response from that minister. When we returned, the next committee of the House of Commons looking at the status of the disabled reintroduced our recommendation for a privacy charter and asked for a response from the Minister of Justice. We did finally receive a response in 1998 or 1999, at which time the ministry responded by saying that the Privacy Act and the Canadian Human Rights Act were going to be reviewed by the minister, and she set up special review committees. She felt that it was not the time to involve herself in the promotion of a charter, but the department recognized that a charter was important with respect to the work that the department was doing.

We have been in touch with the Minister of Justice as recently as within the last week, and it still holds true that people in the department see this as important. They see it, however, as a prologue or as a preamble to a bill on the responsibilities of the Privacy Commissioner. I think one is content and one is container. The question is whether you want the contents or the container or whether they both belong together.

accompli ce travail si important. Je vous pose néanmoins ma question, afin qu'elle figure au compte rendu. Elle porte sur l'encodage des informations, surtout dans le domaine médical. On peut facilement imaginer le jour où nous n'aurons tous qu'un seul dossier médical dont les informations devraient être encodées. À qui ces informations appartiendront-elles? Appartiendront-elles à l'hôpital, au médecin ou au patient?

Le sénateur Finestone: Je peux vous répondre, mais ce ne sera que mon opinion personnelle et c'est une question importante. À mon avis, le dossier médical est un cas de collecte de données qui relèverait du projet de loi C-6. Dès que les dispositions relatives à la santé du projet de loi C-6 entreront en vigueur, entrée en vigueur qui a été reportée d'un an, cette question trouvera sa réponse car c'est l'un des aspects de la protection de la vie privée. C'est une des raisons qui rendent nécessaires une charte du droit à la vie privée. J'estime que c'est à vous qu'appartient votre dossier médical, puisque cette charte du droit à la vie privée protège le droit à la vie privée des personnes au Canada. En ma qualité de citoyenne canadienne vivant dans une société démocratique, je devrais avoir le droit de contrôler les informations qui me concernent. Je devrais avoir le droit de dire: «Oui, il est vrai que vous avez besoin de savoir ceci» ou «non, il ne vous est pas nécessaire de savoir cela». Conformément à son pouvoir réglementaire, le gouvernement a déclaré que, bien que certaines règles pourraient violer votre droit à la vie privée, il peut juger que le système d'encodage appartient au ministère de la Santé. J'ignore quelle est la réponse. Il faudra en débattre.

Le sénateur Fairbairn: Avez-vous discuté de votre charte avec la ministre de la Justice qui, manifestement, aura un rôle important à jouer dans son éventuelle application?

Le sénateur Finestone: Je ne peux que vous faire part de mon expérience personnelle. Nous avons rédigé notre rapport en 1996 et l'avons remis au ministre de la Justice à la Chambre des communes. Il y a ensuite eu des élections et le ministre ne nous a pas répondu. À notre retour, le nouveau comité de la Chambre des communes étudiant la condition des personnes handicapées a redéposé notre recommandation concernant une charte du droit à la vie privée et demandé une réponse à la ministre de la Justice. Nous avons finalement obtenu une réponse en 1998 ou 1999; le ministère a répondu que la Loi sur la protection des renseignements personnels et la Loi canadienne sur les droits de la personne seraient examinées par la ministre et qu'elle avait constitué à cette fin des comités spéciaux. Elle était d'avis que le moment était mal choisi pour elle de promouvoir une charte, mais le ministère reconnaissait qu'une charte était importante puisque cela touchait ses travaux.

Encore la semaine dernière, nous avons communiqué avec le ministère de la Justice et les représentants de ce ministère considèrent toujours cette question importante. Toutefois, ils la voient plutôt comme faisant partie d'un prologue ou d'un préambule à un projet de loi sur les responsabilités d'un commissaire à la vie privée. Pour ma part, j'estime que l'un est le contenu, et l'autre le contenant. Il reste à savoir si vous voulez le contenu, le contenant, ou les deux.

That is where we are at with the Department of Justice. A direct contact with the Minister of Justice has not been made with respect to this bill other than to tell her that she should adopt whatever we do. I thought that would be great information for her because we did all her work.

Honourable senators, I have never drafted a bill before. I have critiqued bills. I have been an opposition member and government member. However, to draft a bill is the most incredible experience. My colleague and friend here had never drafted a bill either. We could not believe how complex the process is, dealing with linguists and legal drafters and translators and weighing every word that the Supreme Court has ever said on sections 7 and 8, and the language that was used in the Universal Declaration of Human Rights, sections 12, 17 and 18, and the language used at the OECD, at the European Union, in Australia and New Zealand, and in the bill that was passed by the Americans. You see how difficult it is to build legislation. My hat goes off to any department that is drafting a bill. It is not easy.

Senator Cohen: I am glad you warned us, Senator Finestone, about this being the first time either of you has drafted a bill, because now we will be very careful when we do clause by clause. Thank you so much for raising the whole issue of privacy and the need to revisit privacy legislation. I note in our briefing book it has been 15 years since some of these privacy issues have been examined. It is time to examine them now.

My question is simple, and I do not know if it falls under Bill C-6 or under the privacy charter. It has to do with lists. When I subscribe to a magazine because I want a certain issue, often my name is passed on to another company, or another group of people whose mail or magazines I do not want coming to my house. Would that fall under this type of legislation or is it already covered elsewhere in another bill?

Senator Finestone: It is a fundamental philosophy that underpins this bill that we as Canadian citizens have the right to privacy and only give up that right with knowing and knowledgeable consent. That was addressed under Bill C-6. It is why the Privacy Commissioner and I are very supportive of that bill. That bill, however, is only one small piece of the pie that is your and my privacy. That matter should be dealt with under Bill C-6, through regulations and through the principle and philosophy that is supposedly expressed in that bill.

Mr. Oscapella: Right now, it is a jurisdictional issue. The lists containing your personal information would probably be held by a private company. Bill C-6, as you know, applies only to the federally regulated private sector at this time and will extend, perhaps after three years, to the provincially regulated sector as well. The situation you described would be covered by Bill C-6 if it were a federally regulated company distributing the lists.

Voilà où nous en sommes avec le ministère de la Justice. Nous avons communiqué directement avec la ministre de la Justice seulement pour lui demander de faire adopter ce projet de loi. Je me suis dit qu'elle serait heureuse d'apprendre que nous avions fait tout ce travail pour elle.

Chers collègues, je n'avais jamais auparavant rédigé un projet de loi. J'ai souvent critiqué des projets de loi. J'ai été députée de l'opposition et députée du parti au pouvoir. Toutefois, rédiger un projet de loi est une expérience incroyable. Mon collègue et ami ici présent n'avait jamais, lui non plus, rédigé un projet de loi. Nous n'aurions pu imaginer comme c'était complexe, faire affaire avec des linguistes, des légistes et des traducteurs, peser chaque mot jamais prononcé par la Cour suprême sur les articles 7 et 8, tenir compte du libellé de la Déclaration universelle des droits de l'homme, des articles 12, 17 et 18, et du libellé employé à l'OCDE, à l'Union européenne, en Australie et en Nouvelle-Zélande, ainsi que dans le projet de loi qui a été adopté par les Américains. Vous voyez comme il est difficile de concevoir une mesure législative. Je lève mon chapeau devant tout ministère qui rédige un projet de loi. Ce n'est pas facile.

Le sénateur Cohen: Je suis heureuse que vous nous ayez prévenus, madame Finestone, du fait qu'il s'agit de votre premier effort de rédaction d'un projet de loi; nous serons très prudents dans notre étude article par article. Merci beaucoup d'avoir soulevé toute cette question de la vie privée et de la nécessité de revoir notre législation à cet égard. Je note que, dans le cahier d'information, on dit qu'il y a déjà 15 ans qu'on s'est penché sur ces questions. Le temps est venu de nous y intéresser à nouveau.

Ma question est simple et je sais qu'elle ne relève pas du projet de loi C-6 ou de la Charte du droit à la vie privée. Elle concerne les listes. Lorsque je m'abonne à un magazine qui m'intéresse, mes coordonnées sont souvent transmises à une autre entreprise ou à un autre groupe de gens dont je ne veux ni les envois, ni les magazines. Ce genre de situation relèverait-il de votre projet de loi ou est-elle déjà prévue dans une autre loi?

Le sénateur Finestone: La philosophie fondamentale qui sous-tend ce projet de loi veut que les citoyens canadiens aient le droit à la vie privée et ne renoncent à ce droit qu'après y avoir consenti de façon éclairée et délibérée. On traite de cela dans le projet de loi C-6. C'est pourquoi le commissaire à la protection de la vie privée et moi avons appuyé ce projet de loi. Toutefois, cette mesure législative ne s'applique qu'à un élément de tout ce qui constitue notre vie privée. Cette situation devrait relever du projet de loi C-6, des règlements connexes et du principe et de la philosophie qui sont censément exprimés dans ce projet de loi.

M. Oscapella: À l'heure actuelle, c'est une question de compétence. La liste où figurent vos informations personnelles est probablement détenue par une entreprise privée. Comme vous le savez, le projet de loi C-6 ne s'applique qu'au secteur privé assujéti à la réglementation fédérale pour l'instant et, peut-être après trois ans, s'appliquera aussi au secteur privé sous réglementation provinciale. La situation que vous avez décrite relèverait du projet de loi C-6 si la liste est distribuée par une entreprise assujéti à la réglementation fédérale.

This legislation is limited in its scope. We hope that it will serve as a template for the provinces and territories, but it will govern only the activities of the federally regulated private sector and governments. We hope it will shine a light on the path and lead the way for the provinces. Again, this would cover personal information about you, as clause 3 says. Essentially, it is a data protection provision that would have paramouncy over Bill C-6 through the way in which it is drafted.

However, the issue is whether that list will be maintained by a federally regulated company. The interface between the various pieces of legislation and the privacy charter will require some working out. Again, this sort of thing happens. We have the Canadian Human Rights Act and the Charter of Rights and Freedoms. They both deal with human rights. There are ways of interpreting them in fashions that are consistent.

Senator Cohen: When I fill out a form or buy a subscription, I write on the form a sort of notice that states, "Please do not pass my name on to any other company." I have been doing that for some time now and it has been helpful.

Senator Finestone: Yesterday, in tributes to Mr. Trudeau, we heard Senator Kinsella allude to the role he played using the Canadian Charter to effect women's fair play and equality. The *Lovelace* case was the first case that tested section 15, the non-discrimination section of the Canadian Charter of Rights. I was on the five-member committee that conducted the review and the research on section 15. It was seen as a magnificent Magna Carta and, hopefully, as a potential for redress in terms of fair pay and fair play. However, it did not become a reality for all of us. We did not see it as a mechanism of government and democracy until it was tested by the courts. It was Senator Kinsella who did that. That opened a floodgate of close to 300 or 400 decisions that have been taken since. It needed that template. The Charter had a way of bringing this issue to life.

Some of us are very aware of privacy, and some are not so aware that we could lose it. Privacy is not something we want to lose. If we do not want a totalitarian society, if we want a democracy, we need it. That is why this charter could be so effective. It could shine the light and, at the end of the tunnel, we could have legislative remediation as well as more sensitivity and education.

The Deputy Chairman: Thank you, Senator Finestone and Mr. O'Scapella. Your testimony was most informative.

The committee adjourned.

La portée de ce projet de loi est limitée. Nous espérons qu'il servira de modèle aux provinces et territoires, mais il ne régira que les activités des gouvernements et des entreprises du secteur privé sous réglementation fédérale. Nous espérons qu'il ouvrira la voie aux provinces. Encore une fois, l'article 3 de notre projet de loi s'applique aux renseignements personnels qui nous concernent. Essentiellement, c'est une disposition de protection des données qui primerait le projet de loi C-6 en raison de son libellé.

Cependant, il s'agit de savoir si cette liste sera la responsabilité d'une compagnie assujettie à la réglementation fédérale. L'interface entre les diverses lois et la Charte du droit à la vie privée exigera un certain travail. Encore une fois, c'est le genre de chose qui arrive. Il y a la Loi canadienne sur les droits de la personne ainsi que la Charte des droits et libertés. Elles traitent toutes deux des droits de la personne. Il y a des façons logiques de les interpréter.

Le sénateur Cohen: Lorsque je remplis une formule ou que j'achète un abonnement, je rajoute toujours à la main quelque chose du genre « Prière de ne pas communiquer mon nom à d'autres sociétés ». Je fais cela depuis un certain temps déjà et c'est utile.

Le sénateur Finestone: Hier, en rendant hommage à M. Trudeau, nous avons entendu le sénateur Kinsella nous parler du rôle qu'il a joué en se servant de la Charte canadienne pour obtenir l'équité et l'égalité pour les femmes. L'affaire *Lovelace* a été la première affaire soulevée en vertu de l'article 15, l'article de la Charte canadienne des droits portant sur la non-discrimination. J'ai fait partie du comité de cinq membres qui a étudié la question de l'article 15 et a effectué une recherche. C'était considéré comme une magnifique Magna Carta qui, on l'espérait, corrigerait toute iniquité en matière de salaire et de traitement. Cependant, ce n'est pas devenu vrai pour nous tous. C'est devenu un mécanisme du gouvernement et la démocratie seulement après que nos tribunaux en aient été saisis. C'est grâce au sénateur Kinsella que cela s'est fait. C'est ce qui a ouvert la porte aux 300 à 400 décisions qui ont été rendues depuis. Il nous fallait ce modèle. La Charte a servi à donner vie à ce mouvement.

Certains d'entre nous sont très conscients de l'importance de la vie privée et certains autres ne comprennent pas que c'est quelque chose que l'on pourrait perdre. Ce n'est pas quelque chose qu'on veut perdre, la vie privée. Si nous ne voulons pas vivre dans une société totalitaire, si nous voulons la démocratie, alors il nous faut protéger la vie privée. C'est pourquoi cette charte pourrait être si efficace. C'est ce qui servirait de phare et, au bout du tunnel, nous pourrions voir des remèdes législatifs ainsi qu'une meilleure sensibilisation.

La vice-présidente: Merci, sénateur Finestone et M. O'Scapella. Votre témoignage a été des plus instructifs.

La séance est levée.



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WITNESSES—TÉMOINS

The Honourable Sheila Finestone, P.C, Sponsor of the bill;
Eugene Oscapella, Legal Adviser and Specialist in Human
Rights.

L'honorable Sheila Finestone, c.p., parrain du projet de loi;
Eugene Oscapella, conseiller juridique et spécialiste en droits
de la personne.



Second Session
Thirty-sixth Parliament, 1999-2000

SENATE OF CANADA

*Proceedings of the Standing
Senate Committee on*

Social Affairs, Science and Technology

Chairman:
The Honourable MICHAEL KIRBY

Wednesday, October 18, 2000
Thursday, October 19, 2000 (*in camera*)

Issue No. 22

First and last meeting on:

Bill C-41, An Act to amend the statute law
in relation to veterans' benefits

Fourteenth meeting on:

The state of the health care system in Canada

APPEARING:

The Honourable Ronald J. Duhamel, P.C., M.P.,
Minister of Veterans Affairs
and Secretary of State
(Western Economic Diversification)
(Francophonie)

INCLUDING:

THE ELEVENTH REPORT OF THE COMMITTEE
(Bill C-41)

WITNESSES:

(*See back cover*)

Deuxième session de la
trente-sixième législature, 1999-2000

SÉNAT DU CANADA

*Délibérations du comité
sénatorial permanent des*

Affaires sociales, des sciences et de la technologie

Président:
L'honorable MICHAEL KIRBY

Le mercredi 18 octobre 2000
Le jeudi 19 octobre 2000 (à huis clos)

Fascicule n° 22

Première et dernière réunion concernant:

Projet de loi C-41, Loi portant modification
de la législation concernant les avantages
pour les Anciens combattants

Quatorzième réunion concernant:

L'état du système de santé au Canada

COMPARAÎT:

L'honorable Ronald J. Duhamel, c.p., député,
ministre des Anciens combattants
et secrétaire d'État
(Diversification de l'économie
de l'Ouest canadien) (Francophonie)

Y COMPRIS:

LE ONZIÈME RAPPORT DU COMITÉ
(Projet de loi C-41)

TÉMOINS:

(*Voir à l'endos*)



THE STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

The Honourable Michael Kirby, *Chairman*

The Honourable Marjorie LeBreton, *Deputy Chair*

and

The Honourable Senators:

Banks	Fairbairn, P.C.
* Boudreau, P.C.	Keon
(or Hays)	Kennedy
Callbeck	* Lynch-Staunton
Carstairs	(or Kinsella)
Cohen	Meighen
Cook	Robertson

* *Ex Officio Members*

(Quorum 4)

Changes in membership of the committee

Pursuant to rule 85(4), membership of the committee was amended as follows:

The name of the Honourable Senator Fairbairn substituted for that of the Honourable Senator Wiebe (*October 18, 2000*).

The name of the Honourable Senator Wiebe substituted for that of the Honourable Senator Fairbairn (*October 17, 2000*).

The name of the Honourable Senator Meighen substituted for that of the Honourable Senator Beaudoin (*October 17, 2000*).

LE COMITÉ SÉNATORIAL PERMANENT DES
AFFAIRES SOCIALES, DES SCIENCES ET
DE LA TECHNOLOGIE

Président: L'honorable Michael Kirby

Vice-président: L'honorable Marjorie LeBreton

et

Les honorables sénateurs:

Banks	Fairbairn, c.p.
* Boudreau, c.p.	Keon
(ou Hays)	Kennedy
Callbeck	* Lynch-Staunton
Carstairs	(ou Kinsella)
Cohen	Meighen
Cook	Robertson

* *Membres d'office*

(Quorum 4)

Modifications de la composition du comité:

Conformément à l'article 85(4) du Règlement, la liste des membres du comité est modifiée, ainsi qu'il suit:

Le nom de l'honorable sénateur Fairbairn est substitué à celui de l'honorable sénateur Wiebe (*le 18 octobre 2000*).

Le nom de l'honorable sénateur Wiebe est substitué à celui de l'honorable sénateur Fairbairn (*le 17 octobre 2000*).

Le nom de l'honorable sénateur Meighen est substitué à celui de l'honorable sénateur Beaudoin (*le 17 octobre 2000*).

ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Tuesday, October 17, 2000:

Second reading of Bill C-41, An Act to amend the statute law in relation to veterans' benefits.

The Honourable Senator Wiebe moved, seconded by the Honourable Senator Ferretti Barth, that the Bill be read the second time.

After debate,

The Bill was then read the second time.

The question being put on the motion, it was adopted.

The Honourable Senator Wiebe moved, seconded by the Honourable Senator Banks, that the Bill be referred to the Standing Senate Committee on Social Affairs, Science and Technology.

The question being put on the motion, it was adopted.

ORDRE DE RENVOI

Extrait des *Journaux du Sénat* du mardi 17 octobre 2000:

Deuxième lecture du projet de loi C-41, Loi portant modification de la législation concernant les avantages pour les anciens combattants.

L'honorable sénateur Wiebe propose, appuyé par l'honorable sénateur Ferretti Barth, que le projet de loi soit lu la deuxième fois.

Après débat,

Le projet de loi est alors lu la deuxième fois.

La motion, mise aux voix, est adoptée.

L'honorable sénateur Wiebe propose, appuyé par l'honorable sénateur Banks, que le projet de loi soit renvoyé au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

La motion, mise aux voix, est adoptée

Le greffier du Sénat,

Paul C. Bélisle

Clerk of the Senate

MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, October 18, 2000
(30)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, in room 705, Victoria Building, at 4:10 p.m., the Chair, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Banks, Callbeck, Carstairs, Cohen, Cook, Kennedy, Kirby, LeBreton, Meighen and Wiebe (10).

In attendance: From the Research Branch of the Library of Parliament: Grant Purves.

Also in attendance: The official reporters of the Senate.

Pursuant to the Order of Reference adopted by the Senate on Tuesday, October 17, 2000, the committee began its consideration of the Bill C-41, An Act to amend the statute law in relation to veterans' benefits.

APPEARING:

The Honourable Ronald J. Duhamel, P.C., M.P., Minister of Veterans Affairs and Secretary of State (Western Economic Diversification) (Francophonie)

WITNESSES:*Veterans Affairs Canada:*

Larry Murray, Deputy Minister;

Richard A. Brunton, Director, Portfolio Legislation;

Alex Robert, Chief, Legislation (Regulations).

The Chairman made a statement.

Mr. Murray made a statement and, together with Mr. Brunton, answered questions.

The Chairman made a statement.

The Minister made a statement and, together with the other witnesses, answered questions.

It was agreed — That the committee proceed to clause-by-clause consideration of Bill C-41.

It was agreed — That the committee dispense with clause-by-clause consideration of Bill C-41.

It was moved by Senator Carstairs — That Bill C-41 be reported to the Senate without amendment.

The question being put on the motion, it was adopted.

At 5:00 p.m., the committee adjourned to the call of the Chair.

ATTEST:

PROCÈS-VERBAL

OTTAWA, le mercredi 18 octobre 2000
(30)

[Traduction]

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 16 h 10, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Banks, Callbeck, Carstairs, Cohen, Cook, Kennedy, Kirby, LeBreton, Meighen et Wiebe (10).

Également présent: De la Direction de la recherche de la Bibliothèque du Parlement, Grant Purves.

Aussi présents: Les sténographes officiels du Sénat.

Conformément à l'ordre de renvoi adopté par le Sénat le mardi 17 octobre 2000, le comité entreprend son étude du projet de loi C-41, Loi portant modification de la législation concernant les avantages pour les Anciens combattants.

COMPARAÎT:

L'honorable Ronald J. Duhamel, c.p., député, ministre des Anciens combattants et Secrétaire d'État (Diversification de l'économie de l'Ouest canadien) (Francophonie)

TÉMOINS:*Anciens combattants Canada:*

Larry Murray, sous-ministre;

Richard A. Brunton, directeur de la Législation du portefeuille;

Alex Robert, chef de la Législation (Réglementation).

Le président fait une déclaration.

M. Murray fait une déclaration et répond aux questions avec l'aide de M. Brunton.

Le président fait une déclaration.

Le ministre fait une déclaration et répond aux questions avec l'aide des autres témoins.

Il est convenu — Que le comité procède à l'étude article par article du projet de loi C-41.

Il est convenu — Que le comité se passe de l'étude article par article du projet de loi C-41.

Il est proposé par le sénateur Carstairs — Qu'il soit fait rapport du projet de loi C-41 au Sénat sans amendement.

La question, mise aux voix, est adoptée.

À 17 heures, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

OTTAWA, Thursday, October 19, 2000

(31)

[English]

The Standing Senate Committee on Social Affairs, Science and Technology met this day, *in camera*, in room 705, Victoria Building, at 11:04 a.m., the Chair, the Honourable Michael Kirby, presiding.

Members of the committee present: The Honourable Senators Banks, Carstairs, Cook, Kennedy and Kirby (5).

In attendance: From the Research Branch of the Library of Parliament: Odette Madore and Howard Chodos.

Also in attendance: From the office of Senator Kirby: Jeanne Pratt; from the office of Senator Keon: Omar Odeh; Interpreters: Nelly Djahanbin, Carole Levesque and Harriet Smith; Senate Messengers and Console Operators: Lise Bourgoïn and André Pelletier.

Pursuant to the Order of Reference adopted by the Senate on Thursday, December 16, 1999, the committee continued its consideration of the special study on the state of the health care system in Canada. (*For complete text of Order of Reference see Proceedings of the Committee, Issue No. 8.*)

The committee began its consideration of its draft report.

It was agreed — That the draft report be adopted as the report of the committee; and — That the Steering committee and Senator Keon be authorized to make any necessary technical and editing changes to the report prior to tabling.

At 11:25 a.m., the committee adjourned to the call of the Chair.

ATTEST:

OTTAWA, le jeudi 19 octobre 2000

(31)

[Traduction]

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie se réunit aujourd'hui à 11 h 4, à huis clos, dans la pièce 705 de l'édifice Victoria, sous la présidence de l'honorable Michael Kirby (*président*).

Membres du comité présents: Les honorables sénateurs Banks, Carstairs, Cook, Kennedy et Kirby (5).

Également présents: De la Direction de la recherche parlementaire de la Bibliothèque du Parlement, Odette Madore et Howard Chodos.

Aussi présents: Du Bureau du sénateur Kirby: Jeanne Pratt; du Bureau du sénateur Keon: Omar Odedh; interprètes: Nelly Djahanbin, Carole Lévesque et Harriet Smith; messagers du Sénat et opérateurs de console: Lise Bourgoïn et André Pelletier.

Conformément à l'ordre de renvoi adopté par le Sénat le jeudi 16 décembre 1999, le comité poursuit son étude spéciale sur l'état du système de santé au Canada. (*Pour le texte intégral de l'ordre de renvoi, voir les délibérations du comité, fascicule n° 8.*)

Le comité entreprend l'étude de son ébauche de rapport.

Il est convenu — Que l'ébauche du rapport soit adoptée en tant que rapport du comité et que le comité de direction et le sénateur Keon soient autorisés à y apporter les changements techniques et de révision avant son dépôt.

À 11 h 25, le comité suspend ses travaux jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

La greffière du comité,

Catherine Piccinin

Clerk of the Committee

REPORT OF THE COMMITTEE

Thursday, October 19, 2000

The Standing Senate Committee on Social Affairs, Science and Technology has the honour to present its

ELEVENTH REPORT

Your Committee, to which was referred Bill C-41, *An Act to amend the statute law in relation to veterans' benefits*, in obedience to the Order of Reference of Tuesday, October 17, 2000, has examined the said Bill and now reports the same without amendment.

Respectfully submitted,

RAPPORT DU COMITÉ

Le jeudi 19 octobre 2000

Le comité sénatorial permanent des affaires sociales, des sciences et de la technologie a l'honneur de présenter son

ONZIÈME RAPPORT

Votre comité, auquel a été déféré le Projet de loi C-41, *Loi portant modification de la législation concernant les avantages pour les anciens combattants*, conformément à l'ordre de renvoi du mardi 17 octobre 2000, a étudié ledit projet de loi et en fait maintenant rapport sans modifications.

Respectueusement soumis,

Le président,

MICHAEL KIRBY

Chairman

EVIDENCE

OTTAWA, Wednesday, October 18, 2000

The Standing Senate Committee on Social Affairs, Science and Technology, to which was referred Bill C-41, to amend the statute law in relation to veterans' benefits, met this day at 4:10 p.m. to give consideration to the bill.

Senator Michael Kirby (*Chairman*) in the Chair.

[*English*]

The Chairman: Honourable senators, I suggest that we begin.

By way of procedural background, the minister is going to join us as soon as Mr. Martin finishes his economic statement in the House. The vice-chairman of the committee, Senator LeBreton, and I have decided to start the meeting with the departmental officials. The minister is relatively new to his portfolio, having been appointed less than 36 hours ago, and his knowledge of the bill may be limited. We believe, therefore, that the officials can speak knowledgeably about the matter.

Welcome, Mr. Murray.

Mr. Larry Murray, Deputy Minister, Veterans Affairs Canada: Thank you, Mr. Chairman. The minister is looking forward to appearing before your committee. It will be his first committee appearance, and he will be here as soon as possible. I have with me today Mr. Richard Brunton, who is the departmental director of legislation and regulations, and Mr. Alex Robert, our chief of legislation.

I would like to say thank you to the committee, and through the committee to the Senate, for the speed with which you are handling this extremely important bill. We are certainly grateful, and I know that all the people affected are grateful as well.

The bill itself, without stealing too much of my minister's thunder, does three things.

First, it amends the Civilian War-related Benefits Act to extend veterans benefits to all civilian groups who served overseas in close support of the war effort. These include the Canadian Red Cross, St. John's Ambulance, Newfoundland Overseas Foresters Association, the Corps of Canadian Fire Fighters, and the Ferry Command pilots who ferried aircraft across the Atlantic, as well as a few other groups who assisted the military overseas.

Second, it amends the Pension Act to allow Canadian Forces members who have service-related disabilities to collect pensions while still serving, thereby achieving equity with members whose disabilities arose in special duty areas and reserve force service. This will also apply to the Royal Canadian Mounted Police.

TÉMOIGNAGES

OTTAWA, le mercredi 18 octobre 2000

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, auquel a été renvoyé le projet de loi C-41, Loi portant modification de la législation concernant les avantages pour les anciens combattants, se réunit aujourd'hui à 16 h 10 pour étudier ledit projet de loi.

Le sénateur Michael Kirby (*président*) occupe le fauteuil.

[*Traduction*]

Le président: Honorables sénateurs, nous pouvons commencer.

En ce qui concerne le déroulement de la séance, je signale que le ministre doit se joindre à nous dès que M. Martin aura terminé son énoncé économique à la Chambre. La vice-présidente du comité, le sénateur LeBreton, et moi-même avons décidé de commencer la réunion avec les fonctionnaires. Le ministre a reçu récemment son portefeuille, puisqu'il n'y a été nommé qu'il y a 36 heures et peut-être ne connaît-il pas très bien le projet de loi. Nous avons en revanche des fonctionnaires qui peuvent en parler en connaissance de cause.

Soyez le bienvenu, monsieur Murray.

M. Larry Murray, sous-ministre, Anciens combattants Canada: Merci, monsieur le président. Le ministre a prévu de comparaître devant votre comité. Ce sera sa première comparution en comité et il va arriver dès que possible. Je suis aujourd'hui en compagnie de M. Richard Brunton, directeur de la législation et de la réglementation, et de M. Alex Robert, notre chef de la législation.

Je voudrais remercier le comité et, par son intermédiaire, le Sénat pour la rapidité avec laquelle vous avez traité ce très important projet de loi. Nous vous en sommes très reconnaissants, et je sais qu'il en va de même pour toutes les personnes concernées.

Je ne voudrais pas couper l'herbe sous le pied de mon ministre, mais disons que le projet de loi a trois effets importants.

Tout d'abord, il modifie la Loi sur les prestations de guerre pour les civils et étend les prestations pour anciens combattants à tous les groupes de civils qui ont servi outre-mer dans le cadre de l'effort de guerre. C'est notamment le cas des membres de la Croix-Rouge canadienne, de l'Ambulance Saint-Jean, de la Newfoundland Overseas Foresters Association, du Corps des pompiers canadiens et des pilotes du Ferry Command qui ont fait des traversées transatlantiques ainsi que de quelques autres groupes qui ont participé aux activités de l'armée outre-mer.

Deuxièmement, le projet de loi modifie la Loi sur les pensions afin de permettre aux membres des Forces canadiennes atteints d'invalidités liées au service de recevoir des pensions d'invalidité pendant qu'ils sont militaires actifs, de manière à assurer l'égalité avec les membres atteints d'invalidités consécutives au service dans des zones de service spécial et dans les forces de réserve. Cette mesure s'applique aussi à la Gendarmerie royale du Canada.

Third, the bill would make a number of minor, but I believe quite significant and sensible improvements in wording, and if I could call it that, "legislative housekeeping."

Mr. Chairman, since my minister will give a longer statement, perhaps we could go to questions now.

The Chairman: Thank you.

Senator Meighen: Welcome, gentlemen. I will be brief, for reasons to which the chair has alluded.

Mr. Murray, you list a number of support groups to whom coverage is now being extended. Are you aware of any other groups that are not included? If so, for what reason?

Mr. Murray: Are you referring to those groups with overseas service?

Senator Meighen: Yes.

Mr. Murray: I do not believe that any have been excluded. I will ask Mr. Brunton, who is more of a historical expert than I. However, I believe that we have tried to incorporate all the groups that served overseas. A World War I group of canteen workers was originally included in the bill, but we discovered that there were none of them left.

Mr. Richard A. Brunton, Director, Portfolio Legislation, Veterans Affairs Canada: We believe that we have identified all the civilian groups with overseas service under military-type conditions.

Senator Meighen: Am I correct that there is no continuing controversy as to what constitutes overseas service? Does service in Newfoundland or in Prince Edward Island constitute overseas service?

Mr. Brunton: Service in Newfoundland itself does not, but service to get to Newfoundland or to get from Newfoundland to Canada does, as is the same in the case of P.E.I.

Senator Meighen: Let us suppose that I was in ferry command, and my plane crashed between Halifax and Newfoundland?

Mr. Brunton: That would be overseas service.

Senator Murray: To be clear, I believe that one group within ferry command that is not included here is the ground crew who worked on the bases in Canada. They are not included because they do not qualify for that overseas service.

Mr. Brunton: Yes, that is true. However, we did include a special provision that included ground crews if they served overseas, as the armed forces did.

Senator Meighen: Perhaps I am going down a line of questioning here that would be better saved for another day. Let me raise it, and then I will pass on.

Troisièmement, le projet de loi apporte également un certain nombre d'améliorations mineures, mais à mon sens importantes et pertinentes dans la formulation de la loi; c'est pour ainsi dire du «ménage législatif».

Monsieur le président, comme mon ministre va faire une déclaration plus étoffée, nous pouvons peut-être passer dès maintenant aux questions.

Le président: Merci.

Le sénateur Meighen: Merci, messieurs. Je serai bref, pour les raisons mentionnées par le président.

Monsieur Murray, vous avez cité un certain nombre de groupes de soutien auxquels on étend la couverture assurée par la loi. Est-ce que vous connaissez d'autres groupes qui n'en font pas partie? Et dans l'affirmative, pourquoi sont-ils exclus?

M. Murray: Est-ce que vous faites référence à des groupes du service outre-mer?

Le sénateur Meighen: Oui.

M. Murray: Je ne pense pas que des groupes aient été exclus. Je vais demander à M. Brunton, qui est plus versé que moi en histoire. Cependant, je crois que nous avons essayé d'englober tous les groupes qui ont servi outre-mer. Initialement, on avait inscrit dans le projet de loi un groupe de cantiniers de la Première Guerre mondiale, mais nous avons constaté qu'il n'en restait plus un seul de vivant.

M. Richard A. Brunton, directeur, Législation du portefeuille, Anciens combattants Canada: Nous pensons avoir trouvé tous les groupes de civils qui ont assuré un service outre-mer dans des conditions de type militaire.

Le sénateur Meighen: Sauf erreur de ma part, il n'y a plus d'ambiguïté quant à la portée du service outre-mer, n'est-ce pas? Est-ce que le service à Terre-Neuve ou dans l'Île-du-Prince-Édouard constitue du service outre-mer?

M. Brunton: Pas le service à Terre-Neuve à proprement parler, mais le service pour se rendre à Terre-Neuve ou pour aller de Terre-Neuve au Canada en fait partie, et c'est la même chose pour l'Île-du-Prince-Édouard.

Le sénateur Meighen: Supposons que j'ai fait partie du Ferry Command et que mon avion se soit écrasé entre Halifax et Terre-Neuve.

M. Brunton: C'est considéré comme du service outre-mer.

Le sénateur Murray: Disons, pour préciser, qu'un groupe du Ferry Command ne figure pas dans le projet de loi; ce sont les rampants qui ont travaillé dans des bases au Canada. Ils n'y figurent pas, car ils ne sont pas reconnus aux fins du service outre-mer.

M. Brunton: Oui, c'est vrai. Cependant, il y a une disposition spéciale concernant les rampants lorsqu'ils ont servi outre-mer, comme les autres membres des forces armées.

Le sénateur Meighen: Je devrais peut-être réserver mes questions pour un autre jour. Je vais quand même les poser, avant de céder la parole à un autre.

What if one was given no choice and was ordered to stay in Halifax? I know of such a case. An individual who was a medical doctor or a dentist was ordered to stay in Halifax. He worked in the area of pathology to identify people who had been killed, and all that sort of business. He had no choice. He was told to stay in Halifax, yet when it came time to qualify for entry to a veteran's facility, he was denied a place because he had not served overseas.

Mr. Murray: I would argue that that is similar to the Newfoundland forester who goes overseas, tries to join the armed forces and is unable to because his work in the Newfoundland forestry corps in Scotland is deemed essential to the war effort. As a result of that decision, he was not a member of the armed forces during the war, and he did not qualify for benefits until now.

Many of those in the merchant navy services tried to join the armed forces but were too young. Therefore they stayed in the merchant navy because they were doing essential work, and arguably, received fewer benefits.

That is how I personally would view that sort of case. I do not know whether you wish to have additional information?

Senator Meighen: I was going to go on to another area.

Mr. Brunton: Only if you are satisfied with my deputy's answer.

Senator Meighen: I would like to hear your amplification.

Mr. Brunton: I think you are referring to the distinction between those of our veterans who have overseas service and those who have Canada service only. It is true that that distinction has been made and has been with us for many decades.

It is not quite as serious a distinction as it once was. For example, the Canada service veteran always had insurance coverage under the Pension Act, the same as an overseas service veteran. Likewise, a decade or so ago, the Canada service veteran was provided access to the VIP program.

However, the War Veterans Allowance Act was always meant for people who served in combat and served overseas. The theory was that their service in combat rendered them more in need of financial aid from the state, and that this aid should come from the federal level, not the provincial level, as it normally would. That is the rationale. It is based on the distinction that you are questioning.

Senator Meighen: I assume, because I do not see it, that there is no retroactivity here in the payment of any of these allowances?

Mr. Murray: That is the case, Senator Meighen.

Senator Meighen: Was it considered? If so, why was it rejected?

Que se passe-t-il dans le cas de celui qui n'a pas eu le choix et qui a reçu l'ordre de rester à Halifax? Je connais un cas semblable. C'est un médecin ou un dentiste, à qui on a ordonné de rester à Halifax. Il travaillait dans le domaine de la médecine légale et devait identifier des cadavres. Il n'a pas eu le choix. On lui a ordonné de rester à Halifax, mais lorsqu'est venu le temps de demander son admission dans un établissement pour anciens combattants, sa demande a été refusée parce qu'il n'avait pas servi outre-mer.

M. Murray: Je pense que c'est semblable au cas du forestier de Terre-Neuve qui est allé outre-mer, qui a essayé d'entrer dans l'armée et qui n'a pas pu, à cause de son travail au sein du corps des forestiers de Terre-Neuve en Écosse, jugé essentiel à l'effort de guerre. Du fait de cette décision, il n'est pas considéré comme membre des forces armées pendant la guerre et n'avait pas droit aux prestations jusqu'à maintenant.

De nombreux marins de la marine marchande ont essayé d'entrer dans l'armée, mais ils étaient trop jeunes. Ils sont donc restés dans la marine marchande parce qu'ils faisaient un travail essentiel, mais on estime qu'ils n'ont droit qu'à des prestations moindres.

Voilà comment je considère les cas de ce genre. Est-ce que vous voulez des renseignements supplémentaires?

Le sénateur Meighen: Je voudrais continuer dans un autre domaine.

M. Brunton: Seulement si vous êtes satisfait de la réponse de mon sous-ministre.

Le sénateur Meighen: J'aimerais vous entendre la compléter.

M. Brunton: Vous évoquez la distinction entre nos anciens combattants qui ont assuré un service outre-mer et ceux dont le service est limité au Canada. Il est vrai qu'on fait cette distinction depuis plusieurs décennies.

Elle n'est plus aussi importante qu'autrefois. Par exemple, l'ancien combattant qui a servi au Canada est toujours assuré dans le cadre de la Loi sur les pensions, au même titre qu'un ancien combattant qui a servi outre-mer. En outre, il y a une dizaine d'années, l'ancien combattant qui a servi au Canada a eu accès au programme VIP.

Cependant, la Loi sur les allocations aux anciens combattants a toujours été destinée à ceux qui avaient servi au combat et outre-mer. En théorie, leur service au combat justifiait davantage une aide financière de l'État, qui devait venir du niveau fédéral et non pas du niveau provincial, comme c'est le cas normalement. Voilà pour le principe. Il est fondé sur cette distinction que vous évoquez.

Le sénateur Meighen: Comme je ne vois rien à ce sujet, je suppose qu'il n'y a pas de rétroactivité dans le paiement de ces allocations, n'est-ce pas?

M. Murray: En effet, sénateur Meighen.

Le sénateur Meighen: Est-ce qu'on a envisagé une rétroactivité et dans ce cas, pourquoi ne l'a-t-on pas retenue?

Mr. Murray: It was considered. It was examined in great depth. It was determined that we could not accomplish it. To be honest with you, we were concerned that if the bill, for whatever reason, did not make it through the legislative process, the delay in implementing the second provision I mentioned would be too great. That provision is the payment of disability pensions to still-serving members of the Canadian Forces, which was a recommendation of October, 1998.

If this bill were not to make it through, then we would go back and try again for some form of retroactivity. However, it was not possible at the time. Quite frankly, the decision was based on whether or not we could get the bill through now and get on with it.

Senator Meighen: The theory is that a half a loaf is better than no loaf.

Mr. Murray: I hope that it is better than half a loaf.

Senator Meighen: In your opinion, is it a principle that could be revisited?

Mr. Murray: Yes, in certain circumstances it could be.

Senator Meighen: Does it extend to spouses?

Mr. Murray: No, it does not extend to spouses. I am not sure what you mean by that.

Senator Meighen: I refer to survivor benefits.

Mr. Brunton: Senator, are you asking if this bill extends the same benefits to spouses and surviving spouses that it extends to veterans and civilian groups?

Senator Meighen: Yes.

Mr. Brunton: It does indeed. If you look at any of the civilian provisions, any of those civilian groups at the beginning of the bill — it simply states that the Pension Act applies to the civilian group as if that civilian group had been part of the armed forces. That means the entire Pension Act provisions for spouses at the married rate of pension, and the rates for surviving spouses, also apply.

Senator Meighen: Is that only if the beneficiary is alive on the day this bill receives Royal Assent?

Mr. Brunton: No. A widow of a civilian who died 20 years ago — who was ineligible or perhaps never received the benefit because it had not been applied for — can be eligible under the Pension Act.

Senator Meighen: Does that also apply without retroactivity?

Mr. Brunton: That is right.

Senator Meighen: Thank you.

The Chairman: We are now delighted to welcome the minister. Congratulations on your appointment.

M. Murray: On l'a envisagée très sérieusement, mais on a constaté qu'il ne pouvait pas y avoir de rétroactivité. En toute franchise, nous avons craint que si, pour une raison ou une autre, le projet de loi ne franchissait pas toutes les étapes de la procédure législative, la deuxième disposition dont j'ai parlé ne pourrait être mise en oeuvre que trop tard. Il s'agit de la disposition sur le versement d'une pension d'invalidité aux membres des forces armées qui sont toujours en service, conformément à une recommandation d'octobre 1998.

Si ce projet de loi n'est pas adopté, nous essaierons de le présenter de nouveau en y ajoutant une forme quelconque de rétroactivité. Ce n'était toutefois pas possible lorsque le projet de loi a été rédigé. À vrai dire, nous avons pris la décision en fonction de la possibilité que le projet de loi soit adopté maintenant.

Le sénateur Meighen: Selon le principe que faute de grives on mange des merles?

M. Murray: J'espère que ce qui est offert vaudra quand même mieux que des merles.

Le sénateur Meighen: À votre avis, pourrait-on revenir sur ce principe?

M. Murray: Oui, dans certaines circonstances.

Le sénateur Meighen: Cela s'applique-t-il aux conjoints?

M. Murray: Non, cela ne s'applique pas aux conjoints. Je ne suis pas certain de ce que vous entendez par là, d'ailleurs.

Le sénateur Meighen: Je parle des prestations au conjoint survivant.

M. Brunton: Sénateur, vous voulez savoir si ce projet de loi offre aux conjoints et aux conjoints survivants les mêmes prestations qu'aux anciens combattants et aux groupes de civils?

Le sénateur Meighen: Oui.

M. Brunton: Oui, en effet. Si vous lisez les dispositions relatives aux civils, à tous ces groupes de civils, au début du projet de loi — on y dit que la Loi sur les pensions s'applique aux groupes de civils qui ont servi comme membres des forces armées. Cela signifie que toutes les dispositions de la Loi sur les pensions s'appliquent aux conjoints, au taux de pension des conjoints et aux taux applicables aux conjoints survivants.

Le sénateur Meighen: Cela s'applique-t-il seulement si le bénéficiaire est vivant le jour où ce projet de loi reçoit la sanction royale?

M. Brunton: Non. Le conjoint survivant d'un civil décédé il y a 20 ans — qui n'avait pas le droit aux prestations ou ne les a peut-être jamais reçues parce qu'il ne les avait pas demandées — a droit à ces prestations sous le régime de la Loi sur les pensions.

Le sénateur Meighen: Mais il n'y a pas de rétroactivité non plus dans ce cas?

M. Brunton: C'est exact.

Le sénateur Meighen: Merci.

Le président: Nous avons maintenant le plaisir d'accueillir le ministre. Nous vous félicitons de votre nomination.

[Translation]

The Honourable Ronald J. Duhamel, PC, MP, Minister of Veterans Affairs and Secretary of State (Western Economic Diversification) (Francophonie): Honourable senators, I am very pleased to appear before you today regarding Bill C-41. Having attended similar meetings with senators in the past, I must say that I always found they were very well prepared and asked very good questions. That is a bit intimidating for a new minister.

Allow me first of all to pay tribute to the protagonist of this bill, my predecessor in the position of Minister of Veterans Affairs, the Honourable George Baker.

We are all familiar with his unconditional dedication to the cause of veterans. I am thinking more specifically of the veterans of the merchant marine, civilians who served in wartime and current members of the Canadian Armed Forces who will benefit from this bill.

It will be difficult to succeed George S. Baker. I can only promise to do my best for Canada's veterans and peacekeepers. My commitment in this regard is profound and sincere.

[English]

As you well know, I am here today to request your support for the speedy passage of this bill. I have been a minister for a very short time.

[Translation]

I am counting on your indulgence and patience. The tenor of the bill was explained to me and I understand its major aspects. I am accompanied today by Mr. Larry Murray, Deputy Minister of Veterans Affairs, Mr. Richard A. Brunton, Director of Legislation and Regulations, and Mr. Alex Robert, Chief of Legislation. We should therefore be able to answer your questions about Bill C-41.

I would hope that we might achieve speedy passage of this bill because it contains, I believe, long-awaited and much-sought-after benefit enhancements for wartime civilian groups and the modern Canadian forces. The wartime civilian groups include such heroic organizations as the Ferry Command, the Canadian Fire Fighters in the United Kingdom, the Red Cross nurses, and the Newfoundland Foresters.

These groups served overseas alongside the Canadian forces, and under similar military-type conditions. Therefore, it seems to me that it only stands to reason that they should have access to the same veterans benefits as military veterans. I am told that Bill C-41 achieves exactly that in terms of veterans disability pensions and income support allowances. I am told that additional regulations are in the works which will grant similar equal access to the veterans health care program.

[Français]

L'honorable Ronald J. Duhamel c.p., député, ministre des Anciens combattants et secrétaire d'État (Diversification de l'économie de l'Ouest canadien)(Francophonie): Honorables sénateurs, je suis très heureux de comparaître devant vous aujourd'hui au sujet du projet de loi C-41. Je dois vous dire, ayant déjà assisté à des rencontres semblables avec les sénateurs, que je les ai toujours trouvés très bien préparés et ils posaient de très bonnes questions. C'est un peu intimidant pour un nouveau ministre.

Permettez-moi d'abord de rendre hommage au protagoniste du projet de loi, mon prédécesseur au poste de ministre des Anciens combattants, l'honorable George Baker.

Nous connaissons tous son dévouement inconditionnel à la cause des anciens combattants. Je pense notamment aux anciens combattants de la marine marchande, aux civils qui ont servi en temps de guerre et aux membres actuels des Forces canadiennes qui bénéficieront de ce projet de loi.

Il sera difficile de succéder à George S. Baker. Je peux seulement vous promettre de faire de mon mieux pour les anciens combattants et les gardiens de la paix du Canada. Je prends un engagement profond et sincère à cet égard.

[Traduction]

Comme vous le savez, je suis venu ici vous demander votre appui afin que ce projet de loi soit adopté rapidement. Je suis ministre depuis très peu de temps.

[Français]

Je compte sur votre indulgence et votre patience. On m'a expliqué la teneur du projet de loi et j'en comprends les grandes lignes. Je suis accompagné aujourd'hui de M. Larry Murray, sous-ministre des Anciens combattants, de M. Richard A. Brunton, directeur de la Législation et de la réglementation, et de M. Alex Robert, chef de la législation. Nous devrions donc être en mesure de répondre à vos questions au sujet du projet de loi C-41.

J'espère que nous pourrions adopter ce projet de loi rapidement car il contient, à mon avis, des améliorations attendues et réclamées depuis longtemps aux prestations versées aux groupes de civils qui ont servi durant les guerres et aux forces armées canadiennes modernes. Parmi les groupes de civils qui ont servi durant les guerres, on compte des organismes héroïques comme le Ferry Command, le Corps des pompiers canadiens affectés au service du Royaume-Uni, les infirmières de la Croix-Rouge et les Newfoundland Foresters.

Ces groupes ont servi aux côtés des forces canadiennes, dans des conditions de type militaire semblables. Il me semble donc logique que ces groupes puissent obtenir les mêmes prestations d'anciens combattants que les anciens combattants de l'armée. C'est exactement l'effet du projet de loi C-41, me dit-on, pour ce qui est des pensions d'invalidité des anciens combattants et des allocations de soutien du revenu. On me dit qu'on rédige d'autres règlements afin d'offrir un accès égal au programme de soins de santé des anciens combattants.

For the modern Canadian forces as well as for the RCMP, I am happy to say that the bill brings their disability benefits up to date in the world of workers' compensation. Specifically, it allows pensions for permanent disability to be paid while still serving. Some members of the forces already have this right, namely those whose disabilities arose in peacekeeping operations in what are called "special duty areas," as well as those who become disabled in the reserves. By granting the same right to receive disability benefits before discharge to the rest of our regular forces personnel, we establish equality for all of our Canadian Forces, men and women, who become disabled in the line of duty.

As you know, Bill C-41 is an omnibus bill, so there is a great deal more to it than these two main changes. Much of it is straightforward legislative housekeeping. However, several items are worth mentioning. For instance, Veterans Affairs already has the legislative authority to remit or forgive overpayments of the War Veterans Allowance. The bill extends this authority to overpayments of other veterans benefits such as disability pensions or health care payments. The key advantage of this type of remission authority is that it will allow us to forgive overpayments that are due to administrative error on our part, and are not the fault of an 80-year-old veteran or widow to whom the relatively small amount of money means so very much.

I will not say much more than that, Mr. Chairman. We will be happy to answer any questions that you and the other members of this committee may have. I believe that you may have already started the process. Thank you.

The Chairman: Thank you, minister.

Senator Wiebe: Minister Duhamel, I add my congratulations, not only on your appointment, but on the excellent way in which you presented the case for the bill today. It is a good sign for future committees.

I was very fortunate in that I asked for, and received, an excellent briefing on Bill C-41 from Mr. Brunton, and I thank you for that. Thus, I do not have any questions on Bill C-41, but I sincerely congratulate the department on an excellent piece of proposed legislation. This is something that our veterans have been looking forward to, and it is certainly well deserved.

I was happy to hear that there are some changes in the works that can be handled by regulation. As you know, the Subcommittee on Veterans Affairs is now studying the progress of some of the suggestions that it presented to the department a few years ago. Many of them can be dealt with by regulation and do not require legislation.

Dans le cas des forces canadiennes modernes et de la GRC, je suis heureux de signaler que le projet de loi aligne leurs prestations d'invalidité sur les indemnités versées aux autres travailleurs. Plus précisément, le projet de loi permettra de verser des pensions d'invalidité permanente à des gens qui travaillent encore. Certains membres des forces armées jouissent déjà de ce droit, notamment ceux dont l'invalidité est due à leur service lors d'opérations de maintien de la paix dans ce qu'on appelle des zones de service spécial, ainsi que les personnes rendues invalides dans les forces de réserve. En accordant au reste de notre personnel des forces régulières le même droit d'obtenir des prestations d'invalidité avant leur réforme, nous mettons en place un régime équitable pour tous les hommes et femmes de nos forces canadiennes rendus invalides dans l'exercice de leurs fonctions.

Comme vous le savez, le projet de loi C-41 est une mesure omnibus, ce qui signifie qu'elle contient de nombreuses autres mesures outre ces deux grands changements. En majeure partie, ces dispositions sont d'ordre législatif général. Le projet de loi contient toutefois certaines mesures qu'il faut prendre le temps de mentionner. Par exemple, Anciens combattants Canada possède déjà le pouvoir législatif de renoncer au trop-payé des allocations aux anciens combattants. Le projet de loi étend ce pouvoir au trop-payé d'autres prestations versés aux anciens combattants, entre autres dans le cas des pensions d'invalidité ou des prestations de soins de santé. Le principal avantage de ce pouvoir est qu'il nous permettra de renoncer au remboursement de trop-payé dû à une erreur d'administration de notre part et non dû à une erreur d'un ancien combattant de 80 ans ou de son conjoint pour qui même une somme relativement peu importante a tant de valeur.

Je n'en dirai pas plus, monsieur le président. Nous sommes prêts à répondre aux questions que vous et les autres membres de votre comité souhaitez nous poser. Vous avez peut-être déjà entamé le processus. Merci.

Le président: Merci, monsieur le ministre.

Le sénateur Wiebe: Monsieur le ministre, permettez-moi de vous féliciter également, pas seulement pour votre nomination, mais aussi pour l'excellent plaidoyer que vous nous avez présenté aujourd'hui en faveur de ce projet de loi. Cela augure bien pour les autres comités.

J'ai eu la chance de pouvoir participer, à ma demande, à une excellente réunion d'information sur le projet de loi C-41, avec M. Brunton. Je vous en remercie. Je n'ai donc pas de questions à poser au sujet du projet de loi, mais je tiens à féliciter sincèrement le ministère de l'excellente mesure législative qu'il a proposée. Voilà une mesure qui tenait à coeur à nos anciens combattants et qu'ils méritent, en tout cas.

J'ai été heureux d'entendre que certaines modifications peuvent être apportées au moyen de règlements. Comme vous le savez, le Sous-comité des affaires des anciens combattants étudie à l'heure actuelle les progrès réalisés relativement à certaines propositions qu'il avait présentées au ministère il y a quelques années. Bon nombre des modifications nécessaires pourraient être apportées par règlement au lieu de nécessiter une mesure législative.

I do not want to get into the continuing work of the committee, because this is not the proper time, but I have one question concerning individual veterans who are seeking benefits. There appears to be an onus on the veterans to provide proof that these benefits are actually owing and due to them. Is there anything in this bill, or anything coming up in the future, that would lessen that burden of proof? Sometimes it is difficult for some of the older veterans to provide it.

Mr. Duhamel: Let me say first that I am very sympathetic to your comment. I do not know the answer, but I will ask the officials whether that is a possibility.

Mr. Murray: On the issue of the burden of proof, I sympathize, as does the minister. As the committee is aware, ours is the only legislation in the country, I think, that does give the benefit of the doubt to the applicant. Our pension officers at all 30-some district offices across the country strive mightily to help in every way possible.

We are the only government department, at any level, of which I am aware, that actually has pension advocates, lawyers whose role is to support the applicant at the next two levels if the first decision is not favourable.

Having said that, I also receive letters on the issue of burden of proof and it is something we need to examine. I am not sure whether we can deal with it through regulations. It may be more of a cultural issue. It seems to apply more to the newer veterans, if I can refer to them as that — in other words, the peacekeeping veterans. We are working very hard to establish better communications, better dialogue, a continuing one- or two-day-a-week presence, and to do a better job of case management.

I will ask Mr. Brunton, but I am not aware that we can do much more through regulations, given their nature, but I am not an expert in that area.

Mr. Brunton: There are regulations governing procedure, but the key point here is that, in theory, all war veterans and all modern peacekeeping veterans have a complete record of their medical conditions and what happened during service in their service files.

In theory, the burden of proof is not on the veterans at all. They merely need to apply, to fill out a form, and we will then do all the work. There is usually no question about disabilities of today. When we find that disabilities have a medical link back to something that happened during service, then decisions are made.

My colleagues in the adjudication section tell me that they do invariably apply the benefit of the doubt. Obviously, some applicants will feel that was not done, and my deputy and my minister probably hear more about those cases than about the successes.

Je ne veux pas discuter des travaux du comité, car le moment n'est pas opportun. J'ai toutefois une question au sujet de certains anciens combattants qui demandent à recevoir des prestations. Il semble qu'il incombe aux anciens combattants de démontrer qu'ils ont vraiment droit à ces prestations. Cette mesure législative, ou d'autres mesures à venir, réduisent-elles ce fardeau de la preuve? Il est parfois difficile à certains anciens combattants de fournir cette preuve.

M. Duhamel: Tout d'abord, permettez-moi de dire que je comprends très bien votre observation. Je ne connais pas la réponse, mais je veux demander aux fonctionnaires si c'est possible.

M. Murray: Tout comme le ministre, j'ai beaucoup de sympathie pour les anciens combattants à ce sujet. Comme le comité le sait, notre loi est la seule au pays qui donne au demandeur le bénéfice du doute. Les agents de pension de nos quelque 30 bureaux de district à travers le Canada font tout ce qu'ils peuvent pour aider.

Notre ministère est le seul de tout le gouvernement, de tous les ordres de gouvernement, qui, à ce que je sache, dispose d'avocats dont le rôle est d'aider le demandeur aux deux paliers supérieurs si la décision initiale ne leur est pas favorable.

Cela dit, je reçois également des lettres sur cette question du fardeau de la preuve, et c'est une question qu'il nous faut examiner. Je ne sais pas si nous pouvons la régler au moyen de règlements. Il s'agit peut-être davantage d'une question de culture. Le problème semble toucher davantage les nouveaux anciens combattants, si je puis les appeler ainsi — autrement dit, les anciens combattants d'opérations de maintien de la paix. Nous travaillons avec ardeur pour améliorer les communications et le dialogue, pour mettre en place une présence constante d'un jour ou deux par semaine, et pour améliorer la gestion des cas.

Je vais poser la question à M. Brunton, mais je ne suis pas certain que nous puissions faire davantage au moyen de règlements, compte tenu de leur nature. Je ne suis toutefois pas un expert dans ce domaine.

M. Brunton: La procédure est régie par des règlements, mais l'essentiel, dans ce cas-ci, c'est qu'en théorie, tous les anciens combattants des guerres et tous les anciens combattants des opérations modernes de maintien de la paix possèdent un dossier complet sur leurs problèmes médicaux et sur ce qui leur est arrivé durant leurs années de service.

En théorie, ce ne sont pas les anciens combattants qui assument le fardeau de la preuve. Il leur suffit de présenter une demande, de remplir un formulaire, puis nous faisons tout le travail. Les cas d'invalidité d'aujourd'hui ne posent aucun problème. Si nous constatons qu'une invalidité est médicalement liée à un événement qui s'est produit durant le service, il faut alors prendre des décisions.

Mes collègues du service de règlement des demandes me disent qu'ils appliquent toujours le principe du bénéfice du doute. Évidemment, certains demandeurs ont l'impression que ce n'est pas le cas, et le ministre et mon sous-ministre entendent probablement davantage parler de ces cas-là que des réussites.

Mr. Duhamel: Senator, your question is greatly appreciated. The spirit of your comment has been understood by all of us. We would want to be as flexible, as sensitive, and as helpful as possible.

Senator Wiebe: Thank you. It is wonderful to hear that.

Senator LeBreton: In your presentation, minister, you asked for speedy passage of this bill. I can only say that from our side, the Progressive Conservative side, I totally agree, because none of us would want to suffer the wrath of Elsie Wayne if we ever held this up.

Mr. Duhamel: She asked me my first question.

Senator LeBreton: Then you know how we feel. How many people are presently included in these wartime civilian groups? How many people are we talking about at present?

Mr. Duhamel: I am told there are 1,500 roughly.

Senator LeBreton: Is there any retroactivity in this for the families of people who have passed on? Before you arrived, Senator Meighen was talking about these benefits accruing to spouses or partners. Is there any retroactivity for people who perhaps did not live long enough to have the benefit of this proposed legislation?

Mr. Brunton: There is no retroactivity of payment, but as I said to Senator Meighen, a widow of a civilian who died 20 years ago has the right to apply for a widow's pension on the basis that her late husband should have been given a pension. Her right to that begins on the day that she applies, if the bill is passed.

Senator LeBreton: What is the department doing to communicate with these recipients? Are you just leaving it to the widows or widowers to seek payment themselves? Is some special effort being made to reach out to people who served in these various groups?

Mr. Duhamel: My understanding is that there is such an effort. I would hope so, but I will let the officials give you the specifics.

Mr. Murray: That is an excellent question. We will put the word out as best we can through the Legion and other such organizations. We had a lesson on this recently in the context of the merchant navy compensation package. Since 1992, certain estimates have been made of how many merchant navy veterans would opt for the health care benefits and for the package that we are discussing today. That predicted level was never reached.

In the context of the recent merchant navy compensation package, we sent out individual applications, and we are now being inundated with applications not just for the compensation package, but also for the benefits to which they were entitled but of which, for whatever reason, they were not aware.

M. Duhamel: Sénateur, nous vous savons gré de votre question. Nous avons tous compris dans quel esprit vous faites vos observations. Nous tenons à être aussi souples, aussi sensibles et aussi utiles que possible.

Le sénateur Wiebe: Merci. Je suis ravi d'entendre cela.

Le sénateur LeBreton: Monsieur le ministre, vous avez demandé l'adoption rapide de ce projet de loi. Je peux certainement vous affirmer que, du côté des Progressistes conservateurs, nous sommes tout à fait d'accord, parce qu'aucun d'entre nous ne voudrait subir la colère d'Elsie Wayne si nous en retardions l'adoption.

M. Duhamel: Elle a été la première à me poser une question.

Le sénateur LeBreton: Vous comprenez donc ce que nous ressentons. Combien de gens sont actuellement inclus dans ces groupes de civils ayant participé à l'effort de guerre? De combien de personnes parlons-nous actuellement?

M. Duhamel: On me dit qu'ils sont environ 1 500.

Le sénateur LeBreton: Y a-t-il des mesures de rétroactivité pour les familles des gens décédés? Avant que vous n'arriviez, le sénateur Meighen disait que ces prestations pourraient être payables aux conjoints ou aux partenaires. Y a-t-il des mesures de rétroactivité pour les personnes qui n'ont pas vécu assez longtemps pour bénéficier de la mesure proposée?

M. Brunton: Il n'y a pas de paiement rétroactif, mais comme je l'ai dit au sénateur Meighen, la veuve d'un civil mort il y a 20 ans a le droit de demander une pension de veuve en arguant que son mari aurait dû recevoir une pension. Son droit à ces paiements commence le jour où elle présente sa demande, si le projet de loi est adopté.

Le sénateur LeBreton: Que fait le ministère pour communiquer avec ces prestataires en puissance? Laissez-vous simplement aux veuves ou aux veufs le soin de réclamer les paiements? Prend-on des mesures particulières pour joindre les personnes qui ont été membres de ces divers groupes?

M. Duhamel: Je crois comprendre qu'il y a des efforts déployés en ce sens. Je l'espère, du moins, mais je vais laisser mes adjoints vous donner les détails.

M. Murray: Excellente question. Nous allons faire de notre mieux pour que le message se transmettre, en passant par la Légion et par les autres organismes similaires. Nous avons eu une expérience de cela récemment, dans le contexte de l'indemnisation des marins de la marine marchande. Depuis 1992, on a fait un certain nombre d'estimations du nombre des anciens marins de la marine marchande qui se prévaudraient des avantages quant aux soins de santé et du train de mesure dont nous discutons aujourd'hui. Le niveau prédit n'a jamais été atteint.

Dans le contexte des mesures récentes d'indemnisation des marins de la marine marchande, nous avons envoyé des formulaires individuels et nous sommes maintenant inondés de demandes, non seulement d'indemnisation mais également de prestation des avantages auxquels ils avaient droit, mais dont, pour diverses raisons, ils ignoraient l'existence.

We must pay more attention to our outreach programs. The merchant navy case points out that our past efforts have not been adequate in ensuring that the people who have a right to these benefits are aware of those rights, particularly now that their average age is 79 and a half. We will have to put some effort into that and will be looking at it carefully.

Senator Carstairs: I have a question about an 88-year-old. My father-in-law was in Ferry Command. He was originally a member of the Royal Air Force and was then transferred here to Canada as part of Ferry Command. His wife and son had preceded him because they were both Canadians who came to Canada in 1940. He then made Canada his permanent home in 1943, and has remained here ever since.

I would assume that, under clause 52, he does not qualify here because he was a member of the Royal Air Force. My question is, does he qualify for any veterans health benefits? He does receive a pension from the Royal Air Force, so it is obviously not appropriate for him to also receive a pension from us. It is one or the other, it seems to me. Is he entitled to any health benefits?

Mr. Brunton: The short answer is yes, but maybe I could get details on that case.

Mr. Duhamel: That is a very prudent answer. Thank you.

Mr. Brunton: The case is complex in that he was a member of the RAF. He may or may not have had Canadian domicile when he served as a member of Ferry Command. We would have to look at how exactly it works out. The general rule is that Canada will pay a top-up to any person who served in the British forces and is getting the British pension. As a result of receiving that top-up, they should, in principle, get Canadian veterans health care for that same pension condition. There is a general positivity there.

Mr. Murray: We do have an ongoing relationship with our principal allies — for example, we recently hosted a delegation from the U.K. We compare notes. We track each other's veterans. We ensure that the veterans in question are getting the maximum benefit from either country. You are absolutely correct that they cannot collect a benefit from both, but we do ensure that they are getting the best deal possible from whichever nation it is.

We have very close relationships with the U.K., Norway, Australia and the U.S. to ensure that that happens.

Senator Carstairs: Thank you. I was curious from his perspective, and from that of other veterans who might fit into that particular scenario.

Nous devons accorder une plus grande attention à nos programmes de diffusion de l'information. Le cas de la marine marchande montre que nos mesures antérieures n'ont pas toujours suffi pour que les ayants droit soient mis au courant de leurs droits, surtout maintenant que leur âge moyen est de 79 ans et demi. Nous devons investir certains efforts là-dedans et nous examinerons cela soigneusement.

Le sénateur Carstairs: Je voudrais poser une question au sujet d'une personne âgée de 88 ans. Mon beau-père a servi dans les traversiers en service commandé. À l'origine, il était membre de la Royal Air Force. Il a ensuite été transféré ici, au Canada, pour naviguer à bord des traversiers en service commandé. Sa femme et son fils l'avaient précédé, parce qu'ils étaient tous deux des Canadiens, arrivés au Canada en 1940. Il a ensuite élu domicile de façon permanente au Canada en 1943, et est resté ici depuis.

Je suppose que, en vertu de l'article 52, il n'est pas admissible à des prestations ici, parce qu'il était membre de la Royal Air Force. Voici donc ma question: a-t-il droit à des services de soins de santé pour anciens combattants? Il reçoit bien une pension de la Royal Air Force, et il n'est donc évidemment pas convenable qu'il reçoive également une pension canadienne. Il me semble que c'est l'une ou l'autre. A-t-il droit à des services de santé?

M. Brunton: En bref, la réponse est oui, mais je pourrais peut-être obtenir des détails relatifs à ce cas particulier.

M. Duhamel: C'est une réponse très prudente. Merci.

M. Brunton: La situation est complexe parce qu'il était membre de la RAF. Il s'agit de voir s'il était ou non domicilié au Canada lorsqu'il a servi dans les traversiers en service commandé. Il nous faudrait examiner les détails d'un peu plus près. En règle générale, le Canada paie un supplément de pension à toute personne qui a été membre des Forces armées britanniques et qui reçoit une pension britannique. Du fait que ces personnes reçoivent ce supplément, elles peuvent, en principe, obtenir des soins de santé pour anciens combattants canadiens. En général, on fait bon accueil à ces demandes.

M. Murray: Nous avons des relations suivies avec nos principaux alliés. Par exemple, nous avons récemment accueilli une délégation du Royaume-Uni. Nous comparons nos programmes. Nous assurons de part et d'autre le suivi auprès des anciens combattants des uns et des autres. Nous prenons les mesures nécessaires pour que les anciens combattants obtiennent tous les avantages possibles dans l'un ou l'autre pays. Vous avez parfaitement raison de dire qu'ils ne peuvent pas percevoir des prestations auprès des deux pays, mais nous faisons tout ce qui est nécessaire pour qu'ils bénéficient de la meilleure situation possible, quel que soit leur pays de résidence.

Nous entretenons des relations très étroites avec le Royaume-Uni, la Norvège, l'Australie et les États-Unis, pour coordonner nos programmes.

Le sénateur Carstairs: Merci. Je voulais me renseigner sur sa situation et sur celle d'autres anciens combattants qui pourraient se retrouver dans des circonstances semblables.

On a matter related to veterans health services, although not really to this bill, what is left of those health services? We have closed a number of our veterans hospitals. What is left for veterans in terms of health care services?

Mr. Murray: We actually provide quite extensive health care, depending on the province to some extent, and to be honest, depending on the health care region. We provide three programs.

We provide long-term care for those veterans who qualify — in other words, institutional care.

We provide something called the Veterans Independence Program. It came in in the middle 1980s, and was the first of its kind. It is an excellent program tailored to veterans of a certain age, and includes things like nursing care. It also includes grass cutting, or whatever other services will enable the veteran to remain at home with a quality of life, preferably in a family situation. We do that across the country, and it is an excellent program. Veterans prefer it. It is one-quarter to one-fifth of the cost of institutional care.

We also provide what we call “Health Care Programs,” which includes pharmaceuticals, things like artificial limbs, wheelchairs — all those sorts of things.

We actually have an initiative underway to hopefully tie all those programs together such that we can provide the most sensible package to the individual, catered to the particular veteran and his or her circumstances. It is very extensive. Our budget is about \$2 billion a year, and \$1.2 billion of that goes to disability pensions. Depending on the year, \$550 million to \$600 million a year is spent on health care. It is a very extensive package.

We work extensively with the provinces on the long-term care institutional package. We try to ensure there is a common standard across the country. In fact we are working with the health certification national organization to try to do that. Quite frankly, this committee has made a wonderful contribution to all that with its report on our activities in that area. It has become a blueprint. It arrived just before I did, and I can assure you that it was an excellent report. I think we have just sent the committee an update which I hope will demonstrate clearly that we are doing a lot of work, and that we are following up on your excellent recommendations in that area.

Senator Kennedy: I notice in the clause-by-clause explanation, looking at clause 1 of this bill, that it is described as a catch-all provision intended to include persons as members of various overseas service groups. I am struck by that phrase, “catch-all,” which suggests to me that in drafting this, you have been fairly careful not to be too precise in that first clause because there may

Au sujet des soins de santé accordés aux anciens combattants, bien que cela ne concerne pas vraiment ce projet de loi-ci, que reste-t-il des services de santé en question? Nous avons fermé un certain nombre d'hôpitaux pour anciens combattants. Que reste-t-il aux anciens combattants en matière de services de santé?

M. Murray: En fait, nous offrons des services de santé plutôt poussés, mais cela dépend dans une certaine mesure de la province de résidence et, pour être honnête, de la région où les soins sont dispensés. Nous offrons trois programmes:

Nous offrons des soins de longue durée aux anciens combattants qui y ont droit. Il s'agit, autrement dit, de soins en établissement de santé.

Nous offrons également ce qu'on appelle le Programme pour l'autonomie des anciens combattants. Il a été institué au milieu des années 80, et c'était le premier en son genre. C'est un excellent programme, adapté aux anciens combattants d'un certain âge, et il comprend des services tels que les soins infirmiers. Cela inclut également la tonte du gazon et tous les autres services qui peuvent permettre à un ancien combattant de vivre chez lui, préférablement au sein de sa famille, tout en ayant une certaine qualité de vie. Ce programme a cours au Canada, et il est excellent. Les anciens combattant le préfèrent. Il coûte entre le quart et le cinquième de ce que coûtent les soins en établissement.

Nous offrons aussi ce que nous appelons «le programme de soins de santé», qui inclut les produits pharmaceutiques, les prothèses, les fauteuils roulants et toutes les nécessités du même ordre.

Nous avons récemment lancé une initiative qui, espérons-le, nous permettra d'amalgamer tous ces programmes, de façon à offrir à chaque ancien combattant les services les mieux adaptés à sa situation. Il s'agit d'une initiative très vaste. Notre budget est d'environ 2 milliards de dollars par année, dont 1,2 milliard pour les pensions d'invalidité. Selon l'année, nous dépensons de 550 millions à 600 millions de dollars en soins de santé. Il s'agit d'un programme très vaste.

Nous travaillons considérablement avec les provinces pour les soins de longue durée en établissement. Nous tâchons d'assurer le respect de normes communes à l'échelle du pays tout entier. En fait, nous travaillons avec l'organisme national responsable de l'accréditation en matière de santé pour parvenir à nos fins. Franchement, ce comité a contribué de façon très positive à notre travail grâce à son rapport sur nos activités dans ce domaine. C'est devenu un plan de travail. Il a été produit juste avant que j'arrive au ministère et je peux vous assurer que c'était un excellent rapport. Je crois que nous venons d'envoyer au comité une mise à jour qui, je l'espère, montrera clairement que nous faisons beaucoup de travail et que nous assurons le suivi de vos excellentes recommandations dans ce domaine.

Le sénateur Kennedy: Dans l'explication article par article, au sujet de l'article premier du projet de loi, je note qu'on le décrit comme étant une disposition générale visant à inclure toutes les personnes membres de divers groupes de service outre-mer. Je note particulièrement l'expression «générale», qui montre qu'en rédigeant cet article, vous avez pris bien soin de ne pas être précis,

be groups that you are presently not aware of that might qualify for this. Am I reading that correctly?

Mr. Duhamel: My understanding of "catch-all" is that it identifies the groups that were not previously included. I do not know if it includes a particular group of individuals who have not been identified as a result of this legislative effort. I think that is the point you make, senator. I will turn to those who have the expertise.

Mr. Brunton: That is my work, that catch-all clause.

Senator Kennedy: It is a nice phrase. I am pleased to see it there because it suggests a very positive approach.

Mr. Brunton: Thank you. It was aimed at individuals. We are fortunate that we have fairly complete listings of who served with the civilian groups involved. It will be easy, for example, to verify the service of a Canadian fire fighter because we have a complete listing of their roll call, and similarly for the Red Cross nurses and the St. John's Ambulance. Ferry Command is a little more difficult. There were people coming and going all the time, and they operated under individual contracts. My colleagues and I detected a need to have a catch-all provision that would allow us to include someone even though he or she may not be on the nominal roll.

Your question was whether this provision will allow us to recognize a new group, if there is some other group out there that we simply do not know about. No, it will not. If some other group manifests itself, we will have to return to Parliament to have that group recognized.

Senator Kennedy: The way it is worded, it sounds quite generous, and I commend you on that.

Senator Banks: My question is really not substantive. I will direct it to Mr. Brunton, because it is supplementary to Senator Meighen's earlier questions. I want to find out how sharp the cut-off knife is.

Senator Meighen gave an example of someone in Ferry Command. You explained in answer to his first question that Newfoundland was not overseas per se, if I understood correctly, and that Prince Edward Island was not overseas per se. However, in answer to his second question, if one were shot down while flying from Halifax to St. John's, that would be overseas. What would happen if I were flying from St. John's to Gander? Does it have to do with where my flight began or what my general assignment was, or is it that day, that trip?

Similarly, if I were a member of the merchant marine, I am assuming that if I left Halifax on a trip to Murmansk, that would be overseas. However, if I were on a ship registered in Halifax which had made a run to St. John's, was making its next run to Come By Chance, and suffered a torpedo attack during that time, would I be disqualified for the merchant marine coverage because

parce qu'il peut y avoir des groupes dont vous n'êtes pas actuellement conscients et qui pourraient avoir droit à ces prestations. Mon interprétation est-elle exacte?

M. Duhamel: Si je comprends bien, cette notion de «fourre-tout» correspond aux groupes qui n'avaient pas encore été inclus. Je ne sais si on inclut un groupe donné de particuliers qui n'avaient pas été ciblés suite à cette mesure législative. Je pense que c'est ce que vous voulez dire, sénateur. Je vais faire appel à ceux qui s'y connaissent.

M. Brunton: C'est ce dont je m'occupe, cette disposition fourre-tout.

Le sénateur Kennedy: C'est une belle tournure. Je suis heureuse de cette disposition parce qu'elle correspond à une approche très positive.

M. Brunton: Merci. Elle vise les particuliers. Nous avons la chance d'avoir des listes assez complètes de ceux qui ont servi sous les drapeaux avec les groupes de civils engagés. Il sera facile, par exemple, de vérifier la période de service d'un pompier canadien puisque nous avons un registre complet des listes d'appel, et c'est la même chose pour les infirmières de la Croix-Rouge et de l'Ambulance Saint-Jean. Dans le cas du commandement de traversier, c'est un peu plus difficile. C'était toujours des gens de passage, et ils avaient des contrats individuels. Mes collègues et moi avons senti le besoin d'une disposition fourre-tout qui nous permettrait d'inclure des gens même s'il ou elle n'avait pas figuré sur une liste d'appel.

Vous demandiez si cette disposition nous permettra de reconnaître un nouveau groupe, s'il peut y avoir d'autres groupes dont nous ignorons tout simplement l'existence. Non, ce ne sera pas le cas. Si un groupe se manifeste, nous devons nous adresser à nouveau au Parlement pour le faire reconnaître.

Le sénateur Kennedy: Selon le libellé, c'est une disposition assez généreuse, et je vous en félicite.

Le sénateur Banks: Ma question ne porte pas vraiment sur le fond du projet de loi. Je m'adresse à M. Brunton, parce que ma question fait suite à celle qu'a posée plus tôt le sénateur Meighen. J'aimerais savoir jusqu'à quel point la ligne de démarcation est bien tranchée.

Le sénateur Meighen a donné l'exemple de quelqu'un qui aurait fait partie du commandement de traversier. Vous avez expliqué en réponse à sa première question que Terre-Neuve n'était pas considérée comme une région outre-mer, si j'ai bien compris, et l'Île-du-Prince-Édouard non plus. Toutefois, selon vous, en répondant à sa deuxième question, soit si un avion était abattu au cours d'un vol d'Halifax à St. John's, ce serait considéré comme un déplacement vers l'étranger. Et qu'en serait-il d'un vol de St. John's à Gander? Cela tient-il au point de départ de mon vol ou de ma mission générale, ou des circonstances particulières du cas, du jour, du déplacement?

De la même manière, si je faisais partie de la marine marchande, et que j'ai quitté Halifax en direction de Murmansk, je suppose que ce serait un déplacement outre-mer. Toutefois, si j'étais à bord d'un navire enregistré à Halifax qui s'était rendu à St. John's, et qui se rendait ensuite à Come By Chance, et qui a été torpillé pendant ce trajet, est-ce que je perdrais mon droit à

I left a port in Newfoundland to go to another port in Newfoundland? What about the earlier case, in which I flew from an airport in Newfoundland to another airport in Newfoundland?

Mr. Brunton: A provision in the existing legislation includes any voyage which was attacked by the enemy, or in which your ship was in the company or in the vicinity of a ship that was attacked by the enemy. That would be defined as qualifying service, yes.

Senator Banks: Would a St. Lawrence freighter fall within that qualification?

Mr. Brunton: In the case of the merchant navy, there are a number of indicators of service equivalent to military or defence service. One is that the crew was being paid the war-risk bonus. Another is that the ship was on a foreign voyage. That is a classification under the Canada Shipping Act, and every voyage was classified that way, so we would know. In the case of home trade voyages, there is a requirement that the voyage must have been at least international or interprovincial in order to qualify, unless the crew was receiving the war-risk bonus.

Senator Banks: I am getting picky here, but if I were on a St. Lawrence freighter that sailed from one port in Quebec to another port in Quebec and suffered a torpedo attack — which did happen — I am not qualified for benefits under this bill.

Mr. Brunton: Regrettably, that is incorrect. You are. You most certainly are.

Senator Banks: Then I am glad that you said I was wrong. Thank you.

The Chairman: I have one last question. As someone whose parents were Newfoundlanders and whose relatives all live in Newfoundland, I have not heard of the Newfoundland Foresters. Can you tell me who they are? I find it interesting. Obviously they were not Canadians during the Second World War, since it was before 1949.

I am delighted they were included in the bill, but what is the policy justification for that?

Mr. Murray: It is a fascinating story. During World War I, foresters went from Newfoundland — indeed, I think also from Canada — to serve overseas.

The Chairman: As foresters?

Mr. Murray: Yes. Cutting timber was an essential service, but in World War I apparently there was enough time to make them part of the army, so they went in uniform. When the Newfoundland foresters went in World War II, I gather it had always been the intention that it would be the same. In fact, I understand that they were verbally told that that would be the case. The reality is that they never became part of the army. They remained civilians, they performed an essential service, and as I said, many applied to join the armed forces and in many cases

une indemnité à titre de marin marchand parce que je serais parti d'un port de Terre-Neuve pour me rendre à un autre port de Terre-Neuve? Qu'en est-il du cas précédent, où j'aurais fait un vol à partir d'un aéroport de Terre-Neuve à un autre aéroport de Terre-Neuve?

M. Brunton: Dans la loi actuelle, une disposition inclut tout déplacement au cours duquel il y a eu une attaque par l'ennemi, ou au cours duquel le navire se trouvait dans le voisinage ou à proximité d'un navire qui a été attaqué par l'ennemi. Ce serait un service admissible, oui.

Le sénateur Banks: Est-ce que le service à bord d'un navire de fret sur le Saint-Laurent serait considéré comme admissible?

M. Brunton: Dans le cas de la marine marchande, il y a différents indicateurs de service équivalents aux services militaire ou de défense. Par exemple, l'un des critères consiste à savoir si l'équipage touchait une prime pour risque de guerre. Un autre consiste à savoir si le navire effectuait un voyage outre-mer. C'est une classification établie en vertu de la Loi sur la marine marchande, et tous les déplacements ont été classifiés de cette manière; nous pouvons donc nous y retrouver. Dans le cas des voyages commerciaux au pays, il faut que le voyage ait été au moins international ou interprovincial pour être admissible, à moins que l'équipage ait touché une prime de guerre.

Le sénateur Banks: J'entre dans les détails ici, mais si j'étais à bord d'un navire de fret sur le Saint-Laurent qui se rendait d'un port de Québec à un autre port de Québec et qui a été torpillé — ce qui s'est produit — je n'ai pas droit à des prestations en vertu de ce projet de loi.

M. Brunton: Je regrette, mais ce n'est pas exact. Vous y avez droit. Vous y avez parfaitement droit.

Le sénateur Banks: Alors je me réjouis de vous entendre dire que j'ai tort. Merci.

Le président: J'ai une dernière question. Mes parents étaient de Terre-Neuve et toute ma famille vit à Terre-Neuve, et je n'ai pas entendu parler des forestiers de Terre-Neuve. Pouvez-vous me dire de qui il s'agit? Je trouve le sujet intéressant. Il est bien certain que pendant la Seconde Guerre mondiale, ce n'était pas des Canadiens, puisque c'était avant 1949.

Je suis ravis qu'on les ait inclus dans ce projet de loi, mais quelle en est la justification sur le plan politique?

M. Murray: C'est une histoire fascinante. Pendant la Première Guerre mondiale, les forestiers sont partis de Terre-Neuve — et bien sûr aussi du Canada il me semble — pour servir outre-mer.

Le président: En tant que forestiers?

M. Murray: Oui. L'abattage du bois était un service essentiel, et pendant la Première Guerre mondiale on avait apparemment suffisamment de temps pour les intégrer à l'armée, et ils sont donc partis en uniforme. Quand les forestiers de Terre-Neuve sont partis à la Seconde Guerre mondiale, je pense qu'on avait toujours pensé qu'il en serait de même. En fait, je crois savoir qu'on leur avait dit que ce serait le cas. Le fait est qu'ils n'ont jamais fait partie de l'armée. Ils sont demeurés des civils, ils ont fourni un service essentiel et comme je l'ai dit un bon nombre ont demandé à se

they were not admitted. When they returned they had not been in military service.

I believe many of them were forest workers from the Gander region. I gather this has been an issue for many years. They were entitled to some benefits. In fact all of these groups were entitled to a range of benefits. However, they were all treated somewhat differently, so we have tried here to give them the same benefits as they would have received for military service. I believe there is fairly solid anecdotal evidence that they were promised certain things that, for a variety of reasons, did not happen, but they did perform essential services. They did travel through dangerous waters. They went overseas by ship in convoy.

The Chairman: They did that as Newfoundlanders, not as Canadians, and we have simply said that because they are Canadians now we will include them, the logic being that people who were in both services are entitled to the best pension or best benefits of either country, right?

Mr. Murray: That would be my understanding. Newfoundlanders have become Canadians, so they are all included, whatever their service.

The Chairman: They are counted as being in the Canadian service.

Mr. Murray: We treat them as Canadians.

The Chairman: Would that apply if it were pre-1949?

Mr. Murray: Yes, and I think in every case it was pre-1949. Where it becomes interesting is if there was a Newfoundlander — and I presume there are several — who served in the Royal Navy or the Royal Air Force or the British Army. Then you get into the kind of situation raised by Senator Carstairs, where you actually have someone who was a Newfoundlander then, and is a Canadian now, who served in the RAF.

Mr. Brunton: This is an important part of Newfoundland history, as I have learned, and the key here is to remember that coal was a strategic industry, especially the British coal mines. The coal mines used pit props — large beams — to hold the roofs up; therefore wood became a strategic commodity in both World War I and World War II. In both wars, the Canadian Forestry Corps was part of the Canadian Army, and the British Forestry Corps was part of the British Army. These people had experience as lumberjacks and they were sent up to Scotland, in uniform, to cut all these trees.

In World War II, because of the urgency, as the deputy said, the British government asked the Newfoundland government of the time to send them over without training or putting them into uniform. As a result, 3,680 Newfoundlanders did exactly that — they joined this unit that was created by the Newfoundland government at the request of the British government. That was a huge percentage of the Newfoundland population.

joindre aux forces armées et dans bien des cas ils n'ont pas été admis. À leur retour, on a considéré qu'ils n'avaient pas fait de service militaire.

Je crois qu'un bon nombre d'entre eux étaient des travailleurs forestiers de la région de Gander. Il me semble que la question se pose depuis de nombreuses années. Ils avaient droit à certaines prestations. En fait, tous ces groupes avaient droit à un ensemble d'avantages. Toutefois, ils ont tous été traités de façon assez différente, si bien que nous avons essayé de leur accorder ici les mêmes avantages qu'ils auraient reçus pour le service militaire. Je crois qu'il existe des éléments assez solides pour montrer qu'on leur avait promis certaines choses que pour différentes raisons on ne leur a pas accordées, et qu'ils ont fourni des services essentiels. Ils ont navigué en eaux troubles. Ils sont allés à l'étranger à bord de flottilles de navires.

Le président: Ils l'ont fait en tant que Terre-Neuviens, et non pas en tant que Canadiens, et nous avons simplement dit que parce qu'ils étaient maintenant Canadiens nous allons les inclure, la logique voulant que les gens qui ont participé aux deux services soient autorisés à recevoir les meilleures pensions ou les meilleurs avantages de l'un et de l'autre pays, n'est-ce pas?

M. Murray: C'est ce que je comprends. Les Terre-Neuviens sont devenus des Canadiens et seraient donc inclus, peu importe leur service.

Le président: On estime qu'ils faisaient partie du service canadien.

M. Murray: Nous les considérons comme des Canadiens.

Le président: Serait-ce le cas avant 1949?

M. Murray: Oui. Et je pense que dans tous les cas c'était avant 1949. Ce qui serait intéressant ce serait de voir s'il y a eu des Terre-Neuviens — et je pense qu'il y en a eu plusieurs — qui ont fait partie de la Marine royale ou de la RAF ou de l'Armée britannique. Puis on en arrive à une situation comme celle qu'a évoquée le sénateur Carstairs, où quelqu'un qui était alors Terre-Neuvien, et qui est maintenant Canadien, a servi dans les Forces aériennes royales.

M. Brunton: C'est un élément important de l'histoire de Terre-Neuve, comme je l'ai appris, et l'essentiel est de se rappeler que le charbon était un secteur stratégique, surtout les mines de charbon britanniques. Les mines de charbon utilisaient des étais — de grosses poutres — pour soutenir les toits des galeries; le bois était donc devenu une denrée stratégique pendant la Première et la Deuxième Guerres mondiales. Au cours des deux guerres, les corps de forestiers canadiens faisaient partie de l'Armée canadienne, et les corps de forestiers britanniques faisaient partie de l'Armée britannique. Ces gens avaient de l'expérience comme bûcheron et ils étaient envoyés en Écosse, en uniforme, pour abattre tous ces arbres.

Pendant la Deuxième Guerre mondiale, à cause de l'état d'urgence, comme l'a dit le sous-ministre, le gouvernement britannique a demandé au gouvernement terre-neuvien de l'époque de les envoyer sans formation et même sans uniforme. En conséquence, 3 680 Terre-Neuviens se sont trouvés dans cette situation — ils se sont joints à cette unité créée par le gouvernement terre-neuvien à la demande du gouvernement

The population was approximately 200,000 at the time, and 3,680 of them went overseas to work in Scotland, along with many thousands of Canadian and British army personnel. They worked side by side with veterans and they were told that they would be treated as veterans. When they returned, Newfoundland was beginning the process of deciding whether or not to join Canada. It was also a poor country. It did not have the resources to provide adequate veterans benefits. Therefore, when the terms of union between Canada and Newfoundland were being negotiated in 1948, they included specific provisions whereby Newfoundland veterans — meaning Newfoundlanders who had served in British Forces during World War II — would be treated as Canadian veterans and get the same benefits.

By an accident of history, the Newfoundland foresters, who were supposed to be included in that, were left out. I am told that that occurred because their representative on the team that came from Newfoundland to Ottawa died in the Lord Elgin Hotel the day before the negotiations were to begin.

The Chairman: Thank you for that.

Senator Cohen: If a Canadian spouse were to remarry after the death of a veteran, what would happen to the pension that was due?

Mr. Brunton: Until 1989 that pension would cease, or they would no longer be eligible. An amendment removing that limitation was introduced in 1989 and they would then be eligible for the same pension benefits, whether they remarry or not.

Senator Cook: I was born on the south coast of Newfoundland. Out of the dim recesses of my childhood — and this will date me — I remember hearing stories about Newfoundland men joining the “Free French” and going to St. Pierre. Is there anything in your archives about that?

Mr. Brunton: It is obviously within the realm of possibilities. I expect Canadians did so as well, but I have not uncovered anything about that in my historical research.

Senator Cook: I wondered if there was anyone on my isolated part of the coast that would fall into that category and if they would be eligible.

Mr. Brunton: The Free French was a resistance group and our legislation excludes resistance groups from veteran status.

The Chairman: I thank you for appearing before us.

Honourable senators, are we prepared to proceed to clause by clause?

Hon. Senators: Agreed.

The Chairman: Honourable senators, may I have a motion then to report the bill back to the Senate without amendment?

britannique. Il s’agissait d’un énorme pourcentage de la population terre-neuvienne.

À l’époque, la population de Terre-Neuve était d’environ 200 000, et 3 680 de ces personnes ont fait le voyage outre-mer pour travailler en Écosse, aux côtés de milliers de membres des armées canadiennes et britanniques. Ils ont travaillé aux côtés des anciens combattants et on leur a dit qu’ils seraient traités comme des anciens combattants. Lorsqu’ils sont revenus, Terre-Neuve était en train de décider si elle devait ou non se joindre au Canada. C’était également un pays pauvre. Ils n’avaient pas de ressources pour fournir aux anciens combattants des prestations adéquates. Donc, lorsque furent négociés les termes de l’union entre le Canada et Terre-Neuve en 1948, on a inclus des dispositions précises selon lesquelles les anciens combattants de Terre-Neuve — c’est-à-dire les Terre-Neuviens qui avaient servi les Forces armées britanniques pendant la Deuxième Guerre mondiale — seraient traités comme les anciens combattants canadiens et recevraient le même traitement.

À cause d’un accident de l’histoire, les forestiers terre-neuviens, qui étaient censés faire partie de ce groupe, ont été omis. On me dit que cela s’est produit parce que leur représentant à l’équipe de négociation qui est venu de Terre-Neuve à Ottawa est décédé à l’hôtel Lord Elgin le jour précédent le début des négociations.

Le président: Je vous remercie.

Le sénateur Cohen: Si une épouse canadienne se remariait après le décès d’un ancien combattant, qu’arriverait-il à la pension qui devait être versée?

M. Brunton: Jusqu’à 1989, cette pension aurait cessé d’être versée, ou la personne ne serait plus admissible. Une modification éliminant cette règle fut déposée en 1989 et donc à partir de ce moment-là ces personnes seraient admissibles à la même pension, qu’elles se remarient ou non.

Le sénateur Cook: Je suis née sur la côte sud de Terre-Neuve. Parmi mes premiers souvenirs d’enfance — et je révèle ainsi mon âge — je me souviens avoir entendu parler de Terre-Neuviens qui se sont joints aux armées de la France Libre et qui se sont rendus à Saint-Pierre. Existe-t-il des documents à l’appui dans nos archives à ce sujet?

M. Brunton: Il est évident que c’est possible. Je soupçonne que des Canadiens l’ont fait également, mais je n’ai rien découvert dans mes recherches historiques à ce sujet.

Le sénateur Cook: Je me demandais s’il y avait quelqu’un provenant de ma région isolée de la côte qui ferait partie de cette catégorie et serait donc admissible.

M. Brunton: La France Libre c’était un groupe de résistants et notre législation exclut les groupes de résistants du statut d’ancien combattant.

Le président: Je vous remercie pour votre comparaison.

Honorables sénateurs, sommes-nous prêts à procéder à l’examen article par article?

Des voix: D’accord.

Le président: Honorables sénateurs, puis-je avoir une motion pour faire rapport de ce projet de loi au Sénat sans amendement?

Senator Carstairs: I so move.

Senator LeBreton: I should put on the record that I will second it, so I will not suffer Elsie's wrath.

The Chairman: Yes, we can absolutely do that. We would not want Elsie on your case, or on ours either.

Is it agreed, honourable senators?

Hon. Senators: Agreed.

The Chairman: Thank you. I will report the bill back to the Senate tomorrow without amendment.

The committee adjourned.

Le sénateur Carstairs: Je le propose.

Le sénateur LeBreton: Je veux que ce soit inscrit au procès-verbal que j'appuie cette motion, sinon Elsie m'en voudra à mort.

Le président: Oui, nous pouvons faire cela. Nous ne voulons pas que vous encouriez les foudres d'Elsie, ni nous non plus d'ailleurs.

Vous êtes tous d'accord, honorables sénateurs?

Des honorables sénateurs: D'accord.

Le président: Merci. Je ferai rapport du projet de loi au Sénat demain sans amendement.

La séance est levée.



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Minister of Veterans Affairs and Secretary of State
(Western Economic Diversification) (Francophonie)

L'honorable Ronald J. Duhamel, c.p., député,
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Richard A. Brunton, Director, Portfolio Legislation
Alex Robert, Chief, Legislation (Regulation)

Des Anciens Combattants Canada:

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Richard A. Brunton, directeur de la Législation du portefeuille
Alex Robert, chef de la Législation (Réglementation)



Second Session
Thirty-sixth Parliament, 1999-2000

Deuxième session de la
trente-sixième législature, 1999-2000

SENATE OF CANADA

SÉNAT DU CANADA

Standing Senate Committee on

Comité sénatorial permanent des

**Social Affairs, Science
and Technology**

**Affaires sociales, des
sciences et de la
technologie**

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Président:
L'honorable MICHAEL J.L. KIRBY

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